Physician's Certification for Resident's Need of Power Wheelchair

Resident Name (print): _____

Physician Name (print): _____

I, _____, do here by state and certify that I am

_____'s physician and that upon my face-to-face examination of this resident, I have determined this resident has a substantial medical need for the use of the power wheelchair to maintain the mobility otherwise experienced by an individual of comparative age and that this resident has the physical and mental ability to operate said power wheelchair in such a manner as not to pose a hazard to themselves or others.

_____ _____

Physician's Signature Date

_____ _____

Witness Signature Date

ATTACHMENT A

Power Wheelchair Agreement

(This is a legal document. Read the document carefully and in its entirety before signing.)

I, _____, have requested permission from _____, hereby known as This Facility, to operate and approved power wheelchair on the premises of This Facility. In consideration of my being permitted to operate the power wheelchair on the premises of This Facility and as a condition of me being allowed to operate the power wheelchair on the premises of This Facility agree to the following:

1) I hereby assume all risks, incident to my ownership, operation or use of the power wheelchair.

2) I agree to bear all costs associated with the power wheelchair, including but not limited to the costs of purchase, storage, maintenance or use of the power wheelchair. I agree that This Facility is in no way responsible for any of these costs.

3) I hereby waive, release and forever discharge This Facility and any of its employees or agents from all actions, causes of action, claims, suits, liabilities, losses, damages or costs of any nature which may arise in connection with my ownership, operation or use of the power wheelchair.

4) I hereby agree to indemnity and hold This Facility, its employees and agents harmless from any and all liabilities, losses, damages or costs of any nature which may arise in connection with my ownership, operation or use of the power wheelchair.

5) I hereby agree to be subject to the safety procedures instituted by This Facility for those operating power wheelchairs, including demonstrating my ability to operate the power wheelchair upon reasonable request by This Facility and relinquishing my privilege to operate the power wheelchair upon This Facility's premises when it is determined I am no longer capable of operating the power wheelchair competently, safely or in harmony with others at This Facility.

6) I agree to provide to This Facility, in forms acceptable to it, certification from my medical doctor of my medical need to use the power wheelchair.

7) I agree that this agreement shall bind heirs, my personal representatives and me. I have read this document carefully, in its entirety, and fully understand its contents and sign it voluntarily.

This _____ day of _____, _____.

_____

Resident's Signature

This Power Wheelchair Agreement above was signed by _____ in our presence on the date above stated.

_____

Witness Signature

_____

Witness Signature

ATTACHMENT B

Carolina Therapy Services

Functional Screen for Electric Wheelchairs and Scooters

Patient name: _____

Answer the following questions with yes/no

1. Have any declines been reported by patient or caregivers (ex: falls or cognition)?

2. Can the resident demonstrate safe transfers between surfaces without hands on physical assistance?

3. While in the wheelchair, can the resident lock and unlock brakes, perform stand pivot or sliding board transfers to and from the wheelchair or scooter?

4. Can the resident safely maneuver within a patient room and adjacent corridor, and be able to go to the dining room and social activities without assistance?

5. Can the resident stop the scooter/power wheelchair on command?

6. If the resident is allowed outside, can the resident maneuver the powered mobility device safely thru the doors and in the outside environment?

Problems Noted: _____

Recommendation (Must be completed by therapist): Is the patient safe to continue utilizing the powered mobility device?

_____

Signature of Clinician_____ Date_____

Attachment C