NON-INSURED HEALTH BENEFITS PROGRAM
WHEELCHAIR RECOMMENDATION

In order to support a wheelchair request, the health professional has two options by which to provide their assessment information.

Option 1– Occupational Therapy (OT) or Physiotherapy (PT) Assessment Report

- An OT or PT assessment report may be submitted for a wheelchair request and must include all the information required by the Non-Insured Health Benefits (NIHB) program, including the clinical rationale for the recommended wheelchair and parts. In such situations, the completion of the NIHB Wheelchair Recommendation and Assessment Form is not required.
- The OT or PT assessment report serves as the recommendation.
- Please refer to the Guide and Benefit Lists at the link below for details on required information.

Option 2 – NIHB Wheelchair Recommendation and Assessment Form

This is an **optional form** and serves as a guideline for health professionals to provide the required information for the wheelchair request. An occupational therapist or physiotherapist must complete it.

Part I – Recommendation Form

- A completed Part I is considered a valid prescription or recommendation.
- Part I may be accepted without an OT or PT assessment report only when recommending a manual wheelchair that does not require prior approval. This refers to a wheelchair that has no adjustability, is for part-time use, and the wheelchair cost is generally below the NIHB price.
- When the cost of a wheelchair is over the NIHB price, supporting information including a detailed clinical rationale for the recommended wheelchair and parts must be provided.
- It is important to fill out Part I in full, including the clinical rationale for the chosen make/model, why more cost-effective item(s) do not meet the client's needs, and what models were trialed.
- Supporting information must be provided in one of two ways by the health professional:
    - in a detailed letter or assessment report outlining the necessary information; or
    - by completing Part II of the NIHB Wheelchair Recommendation and Assessment Form.
- Claims with missing information will be put on hold, pending reception of additional information. Please refer to the Guide and Benefit Lists at the link below for details on required information.

Part II – Assessment Form

- Health professionals have the option to use this comprehensive wheelchair assessment form instead of another assessment report or letter template.
- In Part II, health professionals are expected to complete the sections relevant to their client in order to substantiate the wheelchair recommendation. If certain sections are not applicable to the client's situation or to the level of complexity of the recommended wheelchair, health professionals may indicate "not applicable" as needed.

For details regarding eligibility criteria and required information for wheelchair requests, please consult the Medical Supplies and Equipment Guide and Benefit Lists for First Nations and Inuit (sac-isc.gc.ca) > 11.0 Mobility equipment and supplies benefits list > 11.6 Wheelchair.

Indigenous Services Canada | Services aux Autochtones Canada

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Non-Insured Health Benefits (NIHB)
Wheelchair Recommendation & Assessment Form

Protected

This form may be used to recommend manual or power wheelchair coverage for eligible clients under the Non-Insured Health Benefits Program. This form must be completed by an occupational therapist, or physiotherapist, and is considered a valid prescription or recommendation. Benefits covered and their eligibility criteria can be found on the Medical Supplies and Equipment Guide and Benefit Lists at Medical Supplies and Equipment Guide and Benefit Lists for First Nations and Inuit (sac-isc.gc.ca)

PART I: RECOMMENDATION FORM

Section A ***(Check only one, if applicable)***

☐ Palliative Care Client ☐ Client is in a health care facility* – discharge date: (YYYY-MM-DD)

☐ Urgent *If urgent, please explain*:

Section B Client Information (***Please print Illegible or missing fields will cause delays***)

Surname:	Given Names:
Client Address:	Client Phone Number:
Date of Birth: (YYYY-MM-DD)	Client ID#

The Client Identification Number may be one of the following:

- Ten (10) digit Indian Act registration number (also known as Treaty or Status number) for eligible First Nations clients.
- Alpha prefix followed by an eight (8) digit number issued to certain registered First Nations and recognized Inuit clients by NIHB.
- Three (3) digit band number, followed by the five (5) digit family number identifying the family unit within the eligible First Nations client's band.
- Health plan number issued to recognized Inuit clients by the Governments of the Northwest Territories and Nunavut.

Section C Diagnoses

Height: ☐ ft/in ☐ cm Weight: ☐ lbs ☐ kgs

Diagnoses:

Section D Equipment Recommendation

Recommendation:	**Current Wheelchair/Seating System:**	**Concerns with Current Wheelchair/Seating System:**
☐ First Wheelchair ☐ Replacement Wheelchair	Wheelchair Age Cushion Age Backrest Age	

Client/Family/Caregiver Goals for Wheelchair/Seating System:

Notes:	**Clinical rationale:**
1. It is NIHB's expectation that the wheelchair frame recommended is permanent and suitable to meet the client's daily mobility needs for the next 5 years, and the seating recommended is suitable for the next 3 years (2 years for pediatric clients) **2. Manufacturer order form or detailed quote from the manufacturer must be submitted with claims**	- for items recommended - for make and model chosen* - why more cost-effective item(s) do not meet client's needs (*include a separate document if more space is required*)

Wheelchair: ☐ Manual ☐ Power	Make: Model: *** If recommending a carbon fibre, titanium, or power wheelchair, please provide rationale as to why more cost-effective wheelchair does not meet the client's needs** Seat width ☐ in ☐ cm Seat depth ☐ in ☐ cm Finished Seat to floor height ☐ In ☐ cm	
Cushion: ☐ Foam ☐ Air ☐ Gel ☐ Hybrid ☐ Foam/Air ☐ Foam/Gel ☐ Custom	Make: Model: Size: W x D ☐ in ☐ cm	
Backrest: ☐ Tension-adjustable backrest ☐ Solid backrest ☐ Custom	Make: Model: Size: W x H ☐ in ☐ cm	

Other components (please list):	
The wheelchair recommended above:	
Is intended for use in a home setting or other ambulatory care setting	☐ Yes ☐ No
Will meet the client's need for activities of daily living	☐ Yes ☐ No
Considering all options, is the most cost-effective option to meet the client's medical needs and has been trialed and found satisfactory Were other models trialed? Details: _____ For power wheelchair requests, was a manual wheelchair considered? If not, why? _____	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Is expected to meet the client's mobility needs for the next 5 years	☐ Yes ☐ No
Has been trialed and found to be satisfactory	☐ Yes ☐ No

Section E Health Professional Information (***Please print***) *****Form must be dated and signed***	
Surname:	Given Name(s):
☐ Occupational Therapist ☐ Physiotherapist	
License Number: (Provided by your regulatory body)	Office Name/Location:
Phone Number:	Email:
Signature	Date (YYYY-MM-DD):

Privacy statement: The personal information you provide to Indigenous Services Canada (ISC) is governed in accordance with the Privacy Act. We only collect the information needed to administer the NIHB Program. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. For information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the Privacy Act gives you the right to request access to and correction of your personal Information. For more information, please contact ISC's ATIP Coordinator. Contact information can be found at https://www.tbs-sct.canada.ca/ap/atip-aiprp/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.

PART II. ASSESSMENT FORM (Must be completed if no other assessment form is submitted to support the recommendation in Part I.)

Section F Client and Client Health Information

Client Name:	**Date of Birth** (YYYY-MM-DD)
Surgeries: **Past:** **Planned:**	**Cardio-Respiratory Status:** ☐ Intact ☐ Impaired **Details:**

Section G Home Environment information

Client Lives: ☐ Independently ☐ With family/caregivers ☐ Long Term Care ☐ Assisted Living Facility ☐ House ☐ Apartment ☐ Other:

Entrance: ☐ Level ☐ Ramp with safe railing ☐ Lift Entrance width: in ☐ cm ☐

Narrowest Doorway to access: Location: Width: ☐ in ☐ cm

Tight Turns: ☐ No ☐ Yes Location(s)

Flooring: ☐ Carpet ☐ Linoleum/Vinyl Flooring ☐ Hardwood ☐ Ceramic Tile ☐ Other:

Puncture risks (for air cushions) identified in home? ☐ No ☐ Yes (EX: pets with claws, sharps) Details:

Section H Functional Assessment (*Check all that apply)*

Vision:
☐ Within Functional Limits
☐ Impaired
☐ Right Eye
☐ Left Eye
Corrected with glasses:
☐ Yes ☐ No

Hearing:
☐ Within Functional Limits
☐ Impaired
☐ Right ear
☐ Left ear
Using hearing aid(s):
☐ Yes ☐ No

Communication:
☐ Verbal
☐ Non Verbal
☐ Augmentative Communication device** (requires mounting ☐ Yes ☐ No)
☐ Able to direct care
☐ Unable to direct care

Cognition:
☐ Within Functional Limits
☐ Impaired:
☐ Attention
☐ Memory
☐ Problem solving
☐ Judgement/Insight
Describe: _____

Ambulation:
☐ Non-ambulatory
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Unable to ambulate distances within home
☐ No Aid
☐ Cane
☐ Crutches
☐ Standard/2-wheeled walker
☐ 4-wheeled walker
☐ Pediatric gait trainer

Wheelchair Mobility
☐ Full-time ☐ Part-time ☐ Home ☐ Community
Amount of time spent in wheelchair each day: _____
Indoors: ☐ Independent ☐ Assisted ☐ Dependent
Outdoors: ☐ Independent ☐ Assisted ☐ Dependent
Method of manual wheelchair propulsion (select all that apply):
☐ N/A ☐ right arm ☐ left arm ☐ right foot ☐ left foot
Method of power wheelchair control:
☐ N/A ☐ right hand control ☐ left hand control
☐ standard joystick ☐ specialty joystick
Describe:_____
☐ alternative controls - Describe (body part used and control function):

Bed ↔ Wheelchair Transfers:
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Dependent
☐ No Aid
☐ Rail
☐ Transfer belt
☐ Transfer pole
☐ Transfer board
☐ Mechanical lift and sling
☐ Other:

Wheelchair ↔ Toilet/Commode Transfers:
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Dependent
☐ No Aid
☐ Grab bar
☐ Transfer belt
☐ Transfer pole
☐ Transfer board
☐ Toilet safety frame
☐ Mechanical lift and sling
☐ Other: _____

Wheelchair ↔ Vehicle Transfers:
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Dependent
☐ No Aid
☐ Transfer board
☐ Other:

Toileting:
From wheelchair ☐ Yes ☐ No
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please check one)
☐ Dependent

Incontinence:
☐ N/A
☐ Bladder
☐ Bowel
☐ Catheterized
☐ Independent
☐ Assist

Bathing:
From wheelchair: ☐ Yes ☐ No
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Dependent

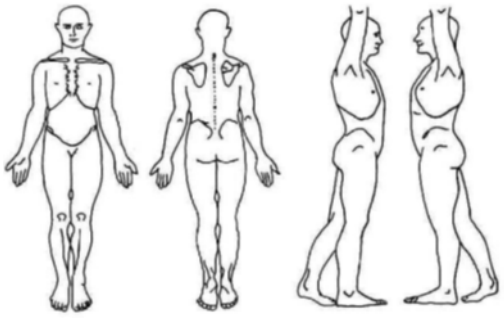
Feeding:
In wheelchair ☐ Yes ☐ No
☐ Feeding tube
☐ Total Parenteral Nutrition (TPN)
☐ History/risk of aspiration
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Dependent

Dressing:
In wheelchair ☐ Yes ☐ No
☐ Independent
☐ Independent with aids
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Dependent

Grooming:
In wheelchair ☐ Yes ☐ No
☐ Independent
☐ Assist x_____ (Nbr of people)
☐ Min ☐ Mod ☐ Max (please select one)
☐ Dependent

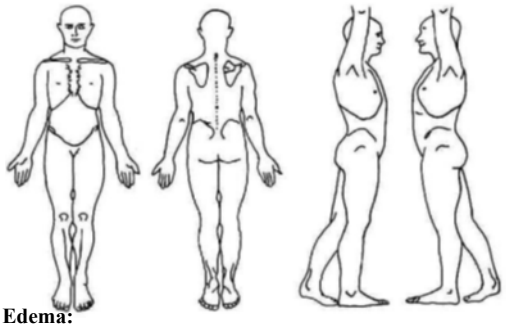
Section I Physical Assessment

Skin Integrity:
Wounds: ☐ Not Applicable ☐ Current ☐ Past
Wound Location(s) (please circle):



Can client reposition independently? ☐ Yes ☐ No
If no, how often is repositioning done? _____
By whom?

Sensation:
☐ Intact ☐ Impaired ☐ Absent
Location(s) of impaired or absent sensation (please circle):



Edema:
☐ None
☐ Yes Location:

[1] School of Physiotherapy, University of South Australia. (n.d.). *Clinical Reasoning Reflection Form*. 1-15. Retrieved November 26th, 2020. https://cdn.ymaws.com /www.ipta.org/resource/resmgr/Treatment_of_Musculoskeletal/CRForm_-_long.pdf.

Tone:
☐ Normal
☐ Hypotonic
☐ Hypertonic
☐ Fluctuating
☐ Involuntary movements affecting sitting

Affecting
☐ Trunk
☐ Upper Extremity ☐ L ☐ R
☐ Lower Extremity ☐ L ☐ R

Pain:
☐ No pain
☐ Pain
Location(s):

☐ Pain limits:
Sitting tolerance ☐ Yes ☐ No
W/C propulsion ☐ Yes ☐ No

Balance:
Standing Balance:
☐ Independent
☐ Minimal support
☐ Moderate support
☐ Unable
Sitting Balance:
☐ Sits unsupported AND shifts weight out of midline
☐ Sits unsupported. Cannot weight shift
☐ Supports with hands in sitting
☐ Requires assistance to remain upright in sitting
☐ Min ☐ Mod ☐ Max (please select one)
Level of Sitting Scale Score (if completed): _____

Range of Motion
Areas of Limitation:

Strength:

	Left	Right
Shoulder	☐ WFL ☐ Limited	☐ WFL ☐ Limited
Elbow	☐ WFL ☐ Limited	☐ WFL ☐ Limited
Wrist	☐ WFL ☐ Limited	☐ WFL ☐ Limited
Hand grip	☐ WFL ☐ Limited	☐ WFL ☐ Limited

Measurements and needs for Accommodation	Objectives	Properties Needed	Products Trialed	Outcome
Pelvis/Hips/Thighs Hip Width: ____ ☐ in ☐ cm Sacrum to Popliteal Fossa length: L __ R ☐ in ☐ cm ☐ Hip flexion limitations: ROM L _____ R _____ ☐ Pelvic Tilt: ☐ Anterior ☐ Posterior ☐ Obliquity: ☐ L ☐ R low ☐ Rotation: ☐ L ☐ R forward Hip Position: ☐ Abducted ☐ L ☐ R ☐ Adducted ☐ L ☐ R ☐ Internally Rotated L ☐ R ☐ ☐ Externally Rotated ☐ L ☐ R ☐ Windswept to ☐ L ☐ R		☐ Cushion rigidizer ☐ Extra cover ☐ Cushion modifications ☐ Residual limb support ☐ L ☐ R ☐ Pelvic positioning belt: ☐ 2 point ☐ 4 point ☐ Padded ☐ Heavy duty cross braces and upholstery ☐ Other:		
Trunk Seat to Shoulder: L ___ R ___ ☐ in ☐ cm Seat to Inferior Angle of Scapula L ___ R ___ ☐ in ☐ cm ☐ Thoracic kyphosis ☐ Lumbar lordosis ☐ Scoliosis: ☐ Rib Hump ☐ L ☐ R		☐ Tension adjustable back upholstery ☐ Recline: ☐ manual ☐ power ☐ Tilt: ☐ manual ☐ power ☐ Dump Rear Seat to floor height ☐ in ☐ cm ☐ Lateral ☐ L ☐ R ☐ Backrest modifications ☐ Other: _____		

☐ Lateral Flexion ☐ L ☐ R ☐ Rotation: ☐ L ☐ R				
Head/Neck Head control: ☐ Good ☐ Limited ☐ Absent Head/Neck Posture: ☐ Flexed ☐ Extended ☐ Laterally Flexed ☐ L ☐ R ☐ Rotated ☐ Cervical hyperextension		Headrest: ☐ small ☐ medium ☐ large Offset ☐ L ☐ R		
Upper Extremities Seat to elbow height: L ____ R ___ ☐ in ☐ cm ☐ Flexor Tone ☐ L ☐ R ☐ Extensor Tone ☐ L ☐ R ☐ Flaccid ☐ L ☐ R Hand dominance ☐ L ☐ R		Armrests: Length ☐ Full ☐ Desk ☐ Height adjustable ☐ Flip back ☐ Removable Tray (describe): Power w/c control: ☐ L ☐ R ☐ Midline ☐ Swing-away ☐ Specialty controls:		
Lower Leg/Ankle/Foot Popliteal fossa to heel: L ____ R ___ ☐ in ☐ cm ☐ Edema ☐ Hamstring limitations: ☐ L ☐ R ☐ Flexor Tone ☐ L ☐ R ☐ Extensor Tone ☐ L ☐ R ☐ Amputation: ☐ Below-knee ☐ L ☐ R ☐ Above-knee ☐ L ☐ R Foot length: L R Foot Positioning: ☐ In ☐ Cm ☐ Dorsiflexion ☐ L ☐ R ☐ Plantar Flexion ☐ L ☐ R ☐ Inversion ☐ L ☐ R ☐ Eversion ☐ L ☐ R		Seat to Floor Height _____ ☐ in ☐ cm Footrest hangers: ☐ 60˚ ☐ 70˚ ☐ 90˚ ☐ Tapered ☐ Specialty foot support (describe): ☐ Calf support (describe): ☐ Elevating leg rest(s): ☐ L ☐ R ☐ manual ☐ power ☐ One piece 90/90 front riggings ☐ Other:		
Additional Options **Please also submit: • NIHB Augmentative and Alternative Communication (AAC) Assessment Form • Communication – Augmentative and Alternative Communication (AAC) Requisition and Prior Approval Form		Tires/wheels: Size ☐ in ☐ cm ☐ Mag ☐ Spoke ☐ Solid ☐ Pneumatic ☐ Specialty tires: ☐ Quick Release Axles ☐ Amputee axle plates ☐ Casters: ☐ in ☐ cm ☐ Brake extensions ☐ Anti tippers ☐ Transit tie-downs ☐ Oxygen holder ☐ Mount for communication aid** ☐ Switch(es) for communication aid** Location(s): ☐ Other:		

Section J Additional Information

Privacy statement: The personal information you provide to Indigenous Services Canada (ISC) is governed in accordance with the Privacy Act. We only collect the information needed to administer the NIHB Program. Collection of information for this purpose is authorized by statute. We require this information for the adjudication and payment of claims and for audit purposes. Your personal information may be disclosed without your consent, but only in accordance with subsection 8(2) of the Privacy Act. For information: This personal information collection is described in Info Source, available online at infosource.gc.ca. In addition to protecting your personal information, the Privacy Act gives you the right to request access to and correction of your personal Information. For more information, please contact ISC's ATIP Coordinator. Contact information can be found at https://www.tbs-sct.canada.ca/ap/atip-aiprp/coord-eng.asp. You also have the right to file a complaint with the Privacy Commissioner of Canada if you think your personal information has been handled improperly.