Applicant's Last Name	First Name	Health Number (10 digits)	Version

Prescription Details for Wheeled Walker Only: (answers required for all specifications)

1. Seat Height _____ ☐ cm or ☐ inches ☐ N/A
2. Push Handle Height _____ ☐ cm or ☐ inches
3. Hand Grips ☐ None ☐ Standard ☐ Anatomical
   Forearm Attachments ☐ One ☐ Two
4. Width Between Push Handles _____ ☐ cm or ☐ inches
5. Client Weight _____ ☐ kg or ☐ lbs
6. Brakes ☐ None ☐ Push -To-Lock ☐ Auto Stop
7. Brake Type ☐ None ☐ Bilateral ☐ One Hand
8. Number of Wheels ☐ Two ☐ Three ☐ Four
9. Wheel Size ☐ 4-6 inches ☐ 6-8 inches ☐ 8-10 inches
10. Back Support ☐ Yes ☐ No

Additional ADP Funded Options Required for Prescribed Device (if applicable check one or more)

☐ Adolescent Size Paediatric Specific Wheeled Walker

☐ Adolescent Size Paediatric Wheeled Walker – Walking Frame

☐ Adolescent Size Paediatric Standing Frame

Non ADP Funded Options Prescribed (Optional)

Set Up Instructions for Vendor (Optional)

☐ **Custom Modifications Required**

The authorizer must provide clinical rationale to support the request in the space below and attach a vendor quote that provides a breakdown of the cost of labour (not to exceed $40.00/hour) and parts.