

# ALBERTA AIDS TO DAILY LIVING (AADL) WHEELCHAIR CUSHION ASSESSMENT TOOL



Client Name (Last) _____ (First) _____		Personal Health Number (PHN) _____		Assessment Date Year _____ Month _____ Day _____	
Authorizer Name (Last) _____ (First) _____		Phone Number Area Code _____ ( _____ ) _____	Authorizer # _____	Assessor Name (Last) _____ (First) _____	

## GENERAL INFORMATION

<b>Client age:</b> _____ yrs. <b>Primary Diagnosis</b> (as related to cushion): _____ _____	Is client on wait list for seating or does he/she need to be referred to seating clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to either, do not order cushion	<b>CONDITION STABILIZED</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Progressive (e.g. ALS, MS CVA)
		<b>WEIGHT OF CLIENT</b> <input type="checkbox"/> Under 250 lbs. <input type="checkbox"/> Over 250 lbs.

## CLIENT DIMENSIONS

		<b>MEASUREMENTS</b>	<b>INCHES</b>
	A	Hip Width	
	B	Rt Thigh Length	
	B	Lt Thigh Length	
	C	Rt Lower Leg Length	
	C	Lt Lower Leg Length	

DEFORMITIES			TONE		INVOLUNTARY MOVEMENT	
	FIXED	FLEXIBLE			TYPE	FREQUENCY
<input type="checkbox"/> Pelvis obliquity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Low/decreased <input type="checkbox"/> High/increased <input type="checkbox"/> Fluctuating		<input type="checkbox"/> Spasm <input type="checkbox"/> Rocking <input type="checkbox"/> Chorea/athetoid type movement	<input type="checkbox"/> Constant <input type="checkbox"/> Occasional
<input type="checkbox"/> Pelvis rotation	<input type="checkbox"/>	<input type="checkbox"/>				
<input type="checkbox"/> Sacral sitter	<input type="checkbox"/>	<input type="checkbox"/>				

## ENVIRONMENT

RESIDENCE	CONSISTENCY OF CAREGIVERS	OTHER ENVIRONMENTS ACCESSED
<input type="checkbox"/> Single dwelling <input type="checkbox"/> Continuing care centre <input type="checkbox"/> Assisted living <input type="checkbox"/> Group home <input type="checkbox"/> Lodge <input type="checkbox"/> In transition (e.g. waiting placement)	<input type="checkbox"/> Multiple <input type="checkbox"/> One/two Caregiver limitation: (e.g. bad back, visual impairment) _____ _____	<input type="checkbox"/> Work/school <input type="checkbox"/> Leisure/recreational <input type="checkbox"/> Inside use only <input type="checkbox"/> Inside and outside use <input type="checkbox"/> Terrain/shock absorption <input type="checkbox"/> Heat/cold/precipitation (temperature may change properties of cushion)

POTENTIAL FOR SKIN BREAKDOWN	SKIN SENSITIVITY	HOURS IN WHEELCHAIR																
<input type="checkbox"/> Current skin breakdown <input type="checkbox"/> History of skin breakdown Braden Risk Assessment Tool <input type="checkbox"/> Attached, or <input type="checkbox"/> See below	<u>Contact allergy</u> <input type="checkbox"/> Yes <input type="checkbox"/> No  <u>Maceration</u> <input type="checkbox"/> Yes <input type="checkbox"/> No  <u>Poor circulation</u> <input type="checkbox"/> Yes <input type="checkbox"/> No  <u>Asensate</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	Time spent in wheelchair without a rest: _____ hrs. Number of times a day in wheelchair: _____ ----- Check to see if pressure is caused by anything other than the cushion. <input type="checkbox"/> Commode/toileting: Sits on commode for ____ min. Pressure relief surface on commode: <input type="checkbox"/> Yes <input type="checkbox"/> No  Other surfaces used: <input type="checkbox"/> Yes <input type="checkbox"/> No (e.g. easy chairs, gerichairs, Broda chairs, bed, tumble forms) <input type="checkbox"/> Clothing (e.g. natural fiber/artificial fibers, seams, pocket contents) <input type="checkbox"/> Other: _____ _____																
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 70%;">Category</th> <th style="width: 30%;">Score</th> </tr> </thead> <tbody> <tr><td>Sensory perception</td><td></td></tr> <tr><td>Moisture</td><td></td></tr> <tr><td>Activity</td><td></td></tr> <tr><td>Mobility</td><td></td></tr> <tr><td>Nutrition</td><td></td></tr> <tr><td>Friction &amp; Shear</td><td></td></tr> <tr><td><b>Total score</b></td><td></td></tr> </tbody> </table> <input type="checkbox"/> Low risk (15 to 16) <input type="checkbox"/> Moderate risk (13 to 14) <input type="checkbox"/> High risk (12 or lower)	Category	Score	Sensory perception		Moisture		Activity		Mobility		Nutrition		Friction & Shear		<b>Total score</b>			
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**BLADDER**

Incontinence interventions:  Catheter  Incontinence supplies  Soaker pads  Other \_\_\_\_\_

Successful intervention:  Yes  No

SITTING BALANCE		TRANSFERS	WEIGHT SHIFTING
<b>LEVELS OF SITTING SCALE (circle appropriate number)</b>		<b>INDEPENDENT</b>	<input type="checkbox"/> Independent <input type="checkbox"/> Partial independent <input type="checkbox"/> Client refuses <input type="checkbox"/> Dependent (e.g. cognitively impaired)
1	Unplaceable	<input type="checkbox"/> Standing	
2	Supported from head downward	<input type="checkbox"/> Sliding	
3	Supported from shoulders or trunk downward	<b>DEPENDENT</b>	
4	Supported at pelvis	<input type="checkbox"/> Standing	
5	Maintains position, does not move	<input type="checkbox"/> Sliding	
6	Shifts trunk forward, re-erects	<input type="checkbox"/> 1 Person Assist	
7	Shifts trunk	<input type="checkbox"/> 2 Person Assist	
8	Shifts trunk backwards, re-erects	<input type="checkbox"/> Mechanical	

**MOBILITY**

**TYPE OF WHEELCHAIR USER (✓ check one)**

LEVEL OF FUNCTIONAL USE	AMOUNT OF TIME WHEELCHAIR USED		
	Occasional	Part time	Full time
Dependent			
Partially independent			
Fully Independent			

**TYPE OF PROPULSION FOR PARTIALLY INDEPENDENT OR FULLY INDEPENDENT USER**

Consideration of impact on cushion, weight bearing, stable surface required for propelling

Foot Propeller  Two Hand Propeller  One arm/one leg  One arm drive  Power

**WHEELCHAIR SPECIFICATIONS**

Seat Width:	Seat to Floor Height:	Weight of Wheelchair:
Seat Depth:	Back Height:	
Back Type: <input type="checkbox"/> Solid <input type="checkbox"/> Upholstery <input type="checkbox"/> Adjustable		Drop Base: <input type="checkbox"/> Yes <input type="checkbox"/> No
Caster Size:		Adjustable Arm Rests: <input type="checkbox"/> Absent
Rear Wheel Size:		Or: <input type="checkbox"/> Wrap <input type="checkbox"/> Parallel <input type="checkbox"/> Flip back

**Goals for wheelchair cushion – Check applicable goals on page 3**

**Decision making tree for recommended cushions (to be developed)**

Product Parameters Required:

Potential Cushions:

Cushion Tried:  Yes  No

**Care & Maintenance of Cushions**

Caregivers informed of cushion care and maintenance:  Yes  No

Caregiver able AND willing to complete cushion care and maintenance:  Yes  No

Cushion transferable between manual and power:  Yes  No **(AADL only pays for one cushion)**



**GOALS FOR REQUESTED/REPLACEMENT CUSHION**

This form & the cushion assessment form are to be completed when requesting a new cushion. Client needs to articulate what is not working with what they have got now, and you would indicate the appropriate goals/outcomes with the new cushion. (Please check ✓ appropriate). You must demonstrate that it meets these goals with a successful cushion trial.

**MOBILITY & FUNCTION**

- N/A
- Client is able to wheel (distance) independently: \_\_\_\_\_
- Client is able to perform ADL activities independently: \_\_\_\_\_  
(eating, transfers, dressing, hygiene, work at the computer, etc.)
- Safety – Client/Caregiver do not have the following safety concern with the new cushion:  
\_\_\_\_\_  
(transport safety, prevent injury during transport)
- Other: \_\_\_\_\_

**PHYSIOLOGICAL SYSTEMS**

- N/A
- Skin Integrity – Requires pressure relief surface  
Client can sit for \_\_\_\_\_ hours without having reddened areas that do not go away within 15-30 minutes of getting out of the chair.
- Less skin care required
- Incontinence Issue (must have this as a goal if cushion replacement is requested due to soiling because of soiling)  
Resolved:  Yes  No If no, why not: \_\_\_\_\_  
(e.g. 101 year old client drinks continuously, in diapers, had incontinent cover – still a problem)

**MUSCULOSKELETAL SYSTEM**

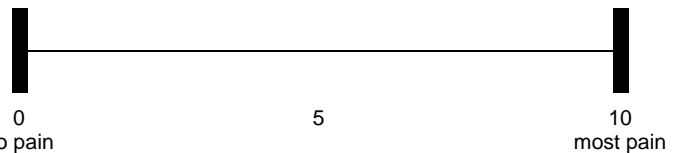
- N/A
- Client does not need repositioning more than once every \_\_\_\_\_ hours  
Before was sliding/leaning/leaning forward and needed repositioning every \_\_\_\_\_ minutes/hours
- Other: \_\_\_\_\_

**COMFORT**

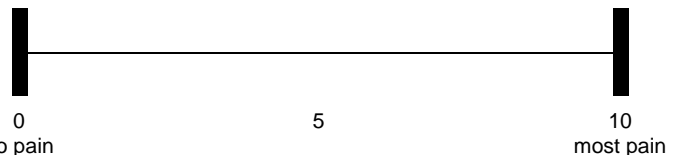
- Client is comfortable sitting in the chair:
- Not squirming
  - No numb bum
  - No hip discomfort
  - No back discomfort
  - No pins and needles
- Other: \_\_\_\_\_
- For \_\_\_\_\_ hours with sitting surface/current cushion
- After \_\_\_\_\_ hours with new cushion

**PAIN**

Draw a line on scale below to indicate pain on sitting surface/current cushion after sitting for \_\_\_\_\_ hours:



Draw a line on scale below to indicate pain on new cushion after sitting for \_\_\_\_\_ hours:



- Reduced use of pain medication (pills/day needed)

**OTHER**