

**ALBERTA AIDS TO DAILY LIVING (AADL)
WHEELCHAIR CUSHION REPLACEMENT REQUEST – CLIENT ISSUE**



Client Name (Last) _____ (First) _____	Personal Health Number (PHN) _____	Assessment Date Year _____ Month _____ Day _____
Authorizer Number: _____	Authorization Number: _____	
Current Cushion: _____	Date Cushion Provided Year _____ Month _____ Day _____	Serial Number: (if applicable) _____
Replacement Cushion Being Requested: _____		AADL Cat. # _____
Current cushion will be recycled if appropriate – client is not allowed to keep the old cushion <input type="checkbox"/> Yes		
Cushion transferable between manual chair and power: <input type="checkbox"/> Yes <input type="checkbox"/> No (AADL only pays for one cushion)		

CLIENT ISSUES

How has the client's condition changed? _____ _____	Condition Prognosis: <input type="checkbox"/> Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Improved
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WHY CUSHION NO LONGER MEETS CLIENT'S NEEDS

<input type="checkbox"/> Skin breakdown/condition (complete rationale) → <input type="checkbox"/> Discomfort/pain <input type="checkbox"/> Wheelchair size changed * <small>(cross reference authorization form) _____</small> <input type="checkbox"/> Mobility change (e.g. foot propeller) <input type="checkbox"/> Seat depth change required * <input type="checkbox"/> Floor to seat height change required (transfer issue) <input type="checkbox"/> Tilt chair (changes type of cushion required) <input type="checkbox"/> Home-like setting changed (positional change not performed as often in some settings) <input type="checkbox"/> Maintenance issues <small>(e.g. air floatation inflation issues, gel requires kneading) *</small> <input type="checkbox"/> Correct orientation of cushion in chair is a problem, <small>e.g. put in backwards (client or caregiver issue) *</small> <input type="checkbox"/> Heat sensitivity to cushion materials – skin temperature <input type="checkbox"/> Safety issues _____ <input type="checkbox"/> Other _____	<p><u>Skin breakdown rationale:</u></p> <input type="checkbox"/> Incontinence <input type="checkbox"/> Positioning <small>(e.g. sacral sitting asymmetrical weight bearing)</small> <input type="checkbox"/> Bony (lost weight or muscle atrophy) <input type="checkbox"/> Weight shifting ability decreased <input type="checkbox"/> Shear/friction wound caused by: <input type="checkbox"/> Transfer issue <input type="checkbox"/> Sliding on current cushion <input type="checkbox"/> Client using transfer board <input type="checkbox"/> Other supporting surfaces impact need for new cushion (skin breakdown resulting from other support surfaces requires pressure relief cushion, change in cushion will not address pressure issues on other surfaces.) <input type="checkbox"/> Bed time increased <input type="checkbox"/> Geri Chair <input type="checkbox"/> Commode Other: _____
<p><u>Braden Score:</u> (Risk of developing pressure ulcers)</p> <input type="checkbox"/> Mild Risk 15 or 16 <input type="checkbox"/> Moderate Risk 13 or 14 <input type="checkbox"/> High Risk 12 or less	

