

Government of Alberta ■

Alberta Aids to Daily Living (AADL) Seating Clinic Referral Form SEATING CLINIC ID _____

DATE	NAME LAST FIRST	M/F	BIRTHDAY (DD/MM/YY)	PERSONAL HEALTH NUMBER
ADDRESS	CITY/TOWN	Residence Type	Postal Code	(Area Code) Phone Number

Contact Person (to arrange appointment): Name: Phone: Relationship:	Additional Contacts (e.g., therapists, family) Name(s): Phone: Relationship:
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Evaluation For (check all that apply)	Seating System	Manual Chair	Power Chair
New	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Growth/Modifications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INDICATE CLIENT'S PREFERRED CHOICE OF WHEELCHAIR/SEATING VENDOR:

MEDICAL STATUS Presenting Condition (including date of onset)	Latex Allergy Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Additional infection controls required
Secondary Diagnosis	Future considerations (planned surgeries, palliative, prognosis)		

FUNDING – All of this section must be completed

Trustee / Person Financially Responsible: _____ Private Funding

Address: _____ Cost Share with AADL

Phone: () _____ Fax: () _____

The Client/Trustee is aware that they may be required to pay a damage deposit/cost-share deposit prior to taking equipment out on trial.

Guardian: _____ Phone: () _____

IDENTIFY which agency will fund seating/mobility and specify reference number:

AADL Benefits AISH SFI WCB Veteran's Affairs MVAC Treaty Band and # _____

Other: _____ Reference # _____ Expiry Date: _____

SEATING CONCERNS

Please identify specific seating needs and functional problems from positioning that you would like seating clinic to address:

These goals are identified by: **(check all that apply)**

Client
 Caregiver
 Health Care Professional

(Check Page 3 to see if additional information required) ** Attach List of Concerns if Needed

POSITIONING

Time spent in wheelchair without a rest _____

Number of times/day _____

Independent weight shifts Yes No

Number of times repositioning is required _____

Client Weight _____ lbs / kg

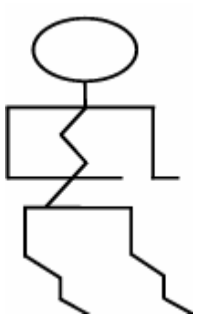
Hip width _____ Thigh Length _____

Is positioning affecting the following functions:

YES	YES	YES
<input type="checkbox"/> Skin Health	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Digestion
<input type="checkbox"/> Bladder	<input type="checkbox"/> Comfort	<input type="checkbox"/> Hand Function
<input type="checkbox"/> Bowel Function	<input type="checkbox"/> Head Control	<input type="checkbox"/> Mobility
<input type="checkbox"/> Swallowing	<input type="checkbox"/> Visual Field	

Comments:

Please describe present seating posture in current seating system/wheelchair:



Attach a photo, if possible, to show seating position

Communication <input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal	Vision <input type="checkbox"/> Normal <input type="checkbox"/> Impaired <input type="checkbox"/> Blind
Aids Used:	Oxygen Dependent <input type="checkbox"/> Yes <input type="checkbox"/> No
Muscle Tone: <input type="checkbox"/> Decreased <input type="checkbox"/> Normal <input type="checkbox"/> Increased	Incontinent of: <input type="checkbox"/> Bladder <input type="checkbox"/> Bowel Catheterized <input type="checkbox"/> Yes <input type="checkbox"/> No

Walking: _____ not at all
 _____ only at home
 _____ lodge/LTC
 _____ in the community

Wheelchair: Power _____ Manual _____
 Independent _____
 Dependent _____
 Most often used _____

If Manual: _____ foot propulsion
 _____ arm propulsion

Activities of Daily Living

Transfers: Independent Assisted Sliding Standing 1-person 2-person Mech.Lift

Feeding: Independent Assisted Dependent

Vocation/School Program _____ School Aide _____ Yes _____ No School Phone _____

SEATING STATUS

Current Seating Equipment:	IVR	Other Seating Equipment:
Type/Brand/Size	Confirmed	Tried
Back _____	<input type="checkbox"/>	_____
Cushion _____	<input type="checkbox"/>	_____
Base _____	<input type="checkbox"/>	_____
Side Supports _____	<input type="checkbox"/>	_____
Tray _____	<input type="checkbox"/>	Other Suggestions:
Headrest _____	<input type="checkbox"/>	
Straps _____	<input type="checkbox"/>	
Other _____	<input type="checkbox"/>	

Wheelchair	<input type="checkbox"/> Manual	<input type="checkbox"/> Power	<input type="checkbox"/> Other	If a new wheelchair/base is required, the specs of the wheelchair frame trialled is attached: <input type="checkbox"/>
Brand				
Width				
Depth				
Serial #				
Condition				
Owner				
Date Received				

Please ensure this form is filled out completely to avoid assessment delay

Person completing this form _____

Designation/Agency _____ Fax: _____

Phone _____

Address _____

Referring Physician _____
 (Sign and print name)

Address _____

CLINIC USE ONLY

Date Received: _____

Action: _____

WHEN EXTRA INFORMATION IS REQUIRED:

- 1. When the client has a pressure ulcer, we ask the therapist or wound care nurse to also include the following information:**
 - Detailed description of the ulcer (exact location, grade of pressure sore, size, shape)
 - History of the ulcer (when it developed, what treatment has been done, what was the outcome)
 - What the suspected source of the ulcer (from bed, from chair, from trauma, etc)
 - What work has been done to ensure other support surfaces do not continue to contribute to the ulcer

- 2. When the client has been sliding forward in the chair, we ask the therapist to include the following information:**
 - If the client foot-propels
 - The length of the leg from the popliteal fossa to the bottom of the usual shoe used
 - The seat-to-floor height of the wheelchair frame (to the top of the seat rail) and also to the top of the cushion
 - What the hamstring range is
 - Describe what has been trialled prior to the referral

- 3. If equipment has been trialled, please describe what worked and what didn't in more detail on the 4th page attached.**

The personal information provided on this form is collected under the authority of the *Alberta Aids to Daily Living and Extended Health Benefits Regulation* and the *Freedom of Information and Protection of Privacy (FOIP) Act* and will be managed in accordance with the *FOIP Act*. The information will be used for the purpose of administering the Alberta Aids to Daily Living Program. If you have any questions about the collection of this information, you can contact the Alberta Aids to Daily Living Program, Health Related Supports, Alberta Seniors and Community Supports, 10th Floor, Milner Building, 10040 – 104 Street, Edmonton, Alberta, T5J 0Z2. Telephone (toll-free in Alberta): 310-0000, then 780-427-0731 when prompted or 780-427-0731; Fax: 780-422-0968.

Equipment Trial Results

Equipment (e.g. 16 x16 x 3 Easy Relax Cushion)	Expected Therapeutic Outcome (e.g. No complaints of discomfort; no red marks after sitting 4 hours)	Results (Feedback from client and other observers) (e.g. Skin and comfort good, but didn't like "plastic" cover)

Client Name:

Trial Dates (approximate):

Feedback from: