Thank you for your interest in our Seating Service. Please note the following:

1. Please ensure that this form is completely filled out. This information determines if we direct your referral to a custom or commercial clinic, and helps us to prearrange equipment if appropriate. (see reverse for "Helpful Hints")

2. If there is additional information that the form does not capture, please add a note to the form.

3. If you are under 18 years of age and have not been seen at the Glenrose for any other intervention, a doctor's referral is required.

   If you are over 18 years of age, a doctor’s referral is required if:
   • You have never been to the Glenrose Seating Service, OR
   • You have not visited our Seating Service in the past ten years, OR
   • Our coordinator feels that you need to see our clinic physician

   The doctor can sign the seating referral form, or sign a prescription with the client’s name and "Refer to Seating Clinic“ on it.

4. Once this is completed, forward to:

   **PEDiATRIC Referrals**
   - Joan Mather
   - Physical Therapy, Pediatrics
   - Seating Service Coordinator
   - Telephone: 780-735-6038
   - Fax: 780-735-6022

   **ADULT Referrals**
   - Ingrid Barlow
   - Occupational Therapy, Adults
   - Seating Service Coordinator
   - Telephone: 780-735-8253
   - Fax: 780-735-7946

**MAILING ADDRESS:**

Glenrose Rehabilitation Hospital
10230 - 111 Avenue
Edmonton, Alberta
T5G 0B7

We look forward to meeting you and being of service in the near future.
HELPFUL HINTS FOR FAMILY/CAREGIVERS/THERAPISTS
WHEN REFERRING TO GLENROSE SEATING CLINIC

- **What equipment does the client have?** Please complete as fully as possible. We need to know if the client still has, and is using, all the components seating provided previously.
- **Preferred seating vendor** (front page, 5th row from top) We work with Eco, Shoppers Capilano and Medichair in Edmonton. If your preference is the one with the shortest waitlist, let us know!
- Please include client's weight in spot provided.

HELPFUL HINTS FOR THERAPISTS when referring to Glenrose Seating Clinic

**Which form do I fill out? Do I have to fill in all the boxes?**

- **B** form - Baseline Questionnaire is not in use right now.
- **Referral form** - the "A" form. Check to see that you are using the most up to date form. Please fill out the form completely. Common areas missed include:
  - **Who is financially responsible?**
    - AISH, AADL, or blank is NOT the answer. If the client manages their own finances, say so. If the client has a trustee, put that in. We need that information for every AADL order!
  - **Client measurements and weight**
    - Also, if the client is asking for a wheelchair change due to weight change, a weight history for the past six months is needed.
- **"J" form** - intended to be used for clients who have had a completely new assessment and seating system provided within the last 12 months, or for clients who need only minor repairs (e.g. belt replacement, not back replacement). If you have any doubt which form to use, complete the "A" form.

**What other things do I need to consider?**

- **Trialling equipment** before seating appointment - If a client needs a new wheelchair frame or cushion, we ask you to decide on the type before clinic so we can concentrate on the issues that only seating clinic is funded to address (e.g. backs, headrests, belts, etc.) Call if you would like some guidance as to which frames or cushions might be appropriate to try. We request that you do not order these ahead of time, but send us the specs and the results of the trial. We may need to have a slightly different size, or consider some other feature when combined with the seating components.

- **If a client has problems with their back (scoliosis or kyphosis), a front view and side view photo of the client in their chair makes it much easier to determine which clinic we will send them to and reduce the amount of written description and follow up phone calls needed to relay the same information. Please use ‘PHOTO’ setting on fax machine, or mail pictures in.**

- **Multiple chairs and seating** - AADL will only pay for one seating system, and expect that it is transferrable between manual and power chairs. They will however, pay for a second set of mounting brackets so the same system can be put safely in the second chair. We have been having some problems lately when a new power chair not ordered by a seating therapist is a different size than the manual chair, and seating doesn’t mesh between the chairs. Please call and discuss this with the Seating Team before the second wheelchair order is finalized.
### SEATING CLINIC REFERRAL

**SEATING CLINIC ID ____________________________**

**DATE**

**NAME**

**LAST**

**FIRST**

**M/F**

**BIRTHDAY (DD/MM/YY)**

**PERSONAL HEALTH NUMBER**

**ADDRESS**

**CITY/TOWN**

**POSTAL CODE**

**AREA CODE**

**PHONE NUMBER**

---

**Contact Person (to arrange appointment):**

**Name:**

**Phone:**

**Relationship:**

---

**Additional Contacts (e.g., therapists, family):**

**Name(s):**

**Phone:**

**Relationship:**

---

**Evaluation For (check all that apply):**

- New
- Seating System
- Manual Chair
- Power Chair

**Growth/Modifications**

---

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

**MEDICAL STATUS**

- Yes/ No-Latex Allergy
- Yes/No-Additional infection controls required

**Presenting Condition (including date of onset):**

**Medications**

---

**Secondary Diagnosis**

**Future considerations (planned surgeries, palliative, prognosis)**

---

**FUNDING – All of this section must be completed**

**Trustee / Person Financially Responsible:** _____________________________________________

**Address:** _____________________________________________________________________

**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)

**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

- Skin Health
- Pulmonary
- Digestion
- Bladder
- Comfort
- Hand Function
- Bowel Function
- Head Control
- Mobility
- Swallowing
- Visual Field

**Comments:**

**Attach a photo, if possible, to show seating position**

---

**Please describe present seating posture in current seating system/wheelchair including range limitations:**

**Attach List of Concerns if Needed**
<table>
<thead>
<tr>
<th>Vision</th>
<th>Normal</th>
<th>Impaired</th>
<th>Blind</th>
<th>Oxygen Dependent</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscle Tone</td>
<td>Decreased</td>
<td>Normal</td>
<td>Increased</td>
<td>Incontinent of:</td>
<td>Bladder</td>
<td>Bowel</td>
</tr>
<tr>
<td>Aids Used:</td>
<td>Oxygen Dependent</td>
<td>Yes</td>
<td>No</td>
<td>Catheterized</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Walking:</td>
<td>not at all</td>
<td>only at home</td>
<td>Independent</td>
<td>Power</td>
<td>Manual</td>
<td>If Manual:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lodge/LTC</td>
<td>Dependent</td>
<td></td>
<td></td>
<td>foot propulsion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in the community</td>
<td>Most often used</td>
<td></td>
<td></td>
<td>arm propulsion</td>
</tr>
</tbody>
</table>

**Activities of Daily Living**

<table>
<thead>
<tr>
<th>Transfers:</th>
<th>Independent</th>
<th>Assisted</th>
<th>Sliding</th>
<th>Standing</th>
<th>1-person</th>
<th>2-person</th>
<th>Mech.Lift</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding:</td>
<td>Independent</td>
<td>Assisted</td>
<td>Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**SEATING STATUS**

<table>
<thead>
<tr>
<th>Current Seating Equipment:</th>
<th>IVR</th>
<th>Other Seating Equipment (use page 4):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cushion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Base</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Side Supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tray</td>
<td></td>
<td>Other Suggestions:</td>
</tr>
<tr>
<td>Headrest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Straps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Wheelchair</th>
<th>Manual</th>
<th>Power</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Width</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serial #</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Received</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- If a new wheelchair/base is required, the specs of the wheelchair frame trialled is attached:

---

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

Person completing this form
Designation/Agency
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 heel 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 did not in more detail on the 4th page attached.

4. If you are requesting a Telehealth assessment, be sure to include the AADL Seating Telehealth Notification Form
## Equipment Trial Results

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Expected Therapeutic Outcome</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>(e.g. 16 x16 x 3 Easy Relax Cushion)</td>
<td>(e.g. No complaints of discomfort; no red marks after sitting 4 hours)</td>
<td>(Feedback from client and other observers) (e.g. Skin and comfort good, but didn’t like “plastic” cover)</td>
</tr>
</tbody>
</table>

- **Client Name:**
- **Feedback from:**
- **Trial Dates (approximate):**