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**SEATING SERVICE**  
**Prosthetics, Orthotics & Seating Department**  
Glenrose Rehabilitation Hospital

Office: 780-735-7937

Fax: 780-735-6027

*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, 5<sup>TH</sup> 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.



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 (use page 4):
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"/>	

<b>Wheelchair</b>	<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 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

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

Client Name:

Feedback from:

Trial Dates (approximate):