Alberta Health Services

# Seating Clinic Referral

| Last Name *(Legal)* | First Name *(Legal)* |
|---|---|
| Preferred Name ☐ Last ☐ First | DOB *(dd-Mon-yyyy)* |
| PHN | ULI ☐ Same as PHN / MRN |
| Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown | |

Ensure referral meets specific referral requirements where these are available. For more information on criteria and where to send the referral visit: www.albertareferraldirectory.ca

If the client requires assistance for any basic care needs during assessment, a caregiver must attend.

**Include with the referral:**

- jpg color photos of the client in their current seating system;
- a record of equipment trialed, if applicable;
- consent to video for virtual assessments, if applicable.

Date *(dd-Mon-yyyy)*

| Person arranging appointment *(name)* | Relationship to client | Phone |
|---|---|---|

Alternate decision maker enacted for ☐ Personal/Health decisions ☐ Financial decisions ☐ Both

| Alternate decision maker *(name)* | Phone | Fax |
|---|---|---|
| Alternate decision maker mailing address | | |
| Alternate **financial** decision maker/trusteee *(name)* | Phone | Fax |

| Mailing Address | Email |
|---|---|
| Client Address | Phone |
| Referring Therapist *(OT/PT only)* | Phone |
| Referring Therapist Email | Work Site |

| Other Therapist *(e.g., school therapist)* | Email | Phone |
|---|---|---|

Who has been informed of the reason for this referral?

☐ Client ☐ Legal Guardian/Alternate Decision Maker ☐ Both

**Special Considerations** ☐ Interpreter required ☐ Physical limitations

☐ Social/Psychological Details _____

## Referral Information

**Reason for referral**

☐ Client has no current seating ☐ Seating system no longer meets current needs and will need adjustment

☐ Client needs replacement of current seating ☐ Other _____

Has a comprehensive seating assessment been completed ☐ No ☐ Yes

If yes, by whom, and where is it charted _____

**Client Concerns** *(check all that apply and specify in comments)*

☐ Sliding ☐ Leaning ☐ Falling ☐ Unable to complete ADL

☐ Skin Integrity ☐ Propulsion ☐ Behaviors

☐ Other *(describe)* _____

_____

Number of times repositioning is required *(e.g., 2 times per hour)* _____

Client receiving services through AHS ☐ No ☐ Yes *(if yes, specify)* _____

Client able to travel to clinic location ☐ No *(if no, specify)* _____ ☐ Yes

Alberta Health Services

# Seating Clinic Referral

| Last Name *(Legal)* | First Name *(Legal)* |
|---|---|
| Preferred Name ☐ Last ☐ First | DOB *(dd-Mon-yyyy)* |
| PHN | ULI ☐ Same as PHN / MRN |
| Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown | |

Preferred vendor *(vendor must be an approved AADL seating vendor)*

**Medical Status** *(include the information most relevant to the client's seating needs)*

Primary Diagnosis

Infection control considerations

Medications that may affect seating

Lack of protective sensation ☐ No ☐ Yes Specify location _____

Client is incontinent of bladder? ☐ No ☐ Yes Effectively managed? ☐ No ☐ Yes

Client is incontinent of bowel? ☐ No ☐ Yes Effectively managed? ☐ No ☐ Yes

Future considerations *(e.g., planned surgeries, prognosis)*

Tubes or Lines Present

**Funding** *(sources of funding for wheelchair and seating equipment)*

☐ Alberta Aids to Daily Living (AADL) Benefits ☐ Cost share ☐ Cost share exempt Ref # _____

☐ Potential for upgrade charges discussed with client

☐ Motor Vehicles Accident Claims (MVAC) Relevant Details *(e.g., company, case #, key contact)* _____

☐ Workers Compensation Board (WCB) Claim # _____

☐ Veterans Affairs Canada (VAC) K# _____

☐ Non-Insured Health Benefits (NIHB) Client Identification Number _____

☐ Other *(e.g., private insurance)* Details _____

**Current Mobility Base**

Wheelchair has angle adjustable back canes ☐ No ☐ Yes

Specification (spec) Sheet attached ☐ No ☐ Yes

Wheelchair on order ☐ No ☐ Yes

Date order submitted _____

Last date wheelchair serviced *(dd-Mon-yyyy)*

| Type | Make | Model | Serial # | Size (WxDxH) | Ownership | Last Date Benefit Received |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

Wheelchair has tilt ☐ No ☐ Yes

Other wheelchair options

**Client Measurements** *(indicate all in **inches**)*

| Hip width | Buttock/Thigh length | Torso width under axilla | Lower leg length |
|---|---|---|---|
| | | | |

Client Weight ☐ lbs ☐ kg

Client weight stable for 3 months? ☐ No ☐ Yes

Comments _____

Alberta Health Services

# Seating Clinic Referral

| Last Name *(Legal)* | First Name *(Legal)* | |
|---|---|---|
| Preferred Name ☐ Last ☐ First | DOB *(dd-Mon-yyyy)* | |
| PHN | ULI ☐ Same as PHN | MRN |
| Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) ☐ Unknown | | |

**Seating components currently in use**

| **Type** | **Description** *(including size)* | **Last date benefits received** |
|---|---|---|
| Cushion | | |
| Solid base | | |
| Backrest | | |
| Headrest | | |
| Belts, straps | | |
| Arm support | | |
| Foot support | | |
| Alternate drive controls | | |
| Other *(specify)* | | |
| Other *(specify)* | | |

**Client Propulsion**

Current Wheelchair Propulsion Method ☐ Power ☐ Manual ☐ Dependent on caregiver

Distance able to self-propel _____m Arms ☐ R ☐ L Foot ☐ R ☐ L

Comment

**Activities of Daily Living**

**Transfers** ☐ Independent ☐ Sliding ☐ Standing
☐ 1-person ☐ 2-person ☐ Mechanical Lift

**Environmental Assessment**

Does the client need the wheelchair (including cushion) to be a specific height for successful transfers?

☐ No ☐ Yes *(details)* _____

Is fitting under a specific table/counter height important to the client?

☐ No ☐ Yes *(details)* _____

Does wheelchair need to be folded?

☐ No ☐ Yes

Is the client able to enter/exit their house in their wheelchair?

☐ No ☐ Yes

Comments