KidsAbility™

APPLICATION - SEATING AND MOBILITY SERVICES

	New Referral: ☐		
Name of Client:			*Male* ☐ *Female* ☐
Date of Birth:			
Diagnosis / Clinical Presentation:			
School:			
Name(s) of Parents:			
Address:			
Home No.:			
Cell No.:		**Email Address:**	
Date of Referral:			
Name of Referral Source:			*O.T.* ☐ *Parent* ☐ *Legal Guardian* ☐
Agency:			
Telephone No.:		**Email Address:**	

O.T.'s involved with this client?

	Name	***Tel. No.***	***Email Address***	***Aware of concerns?*** *Yes* / *No*	
KidsAbility				☐	☐
WWLHIN				☐	☐
Private				☐	☐
Other Therapists				☐	☐

Reason for Referral: *(Consider safety, pain/discomfort, growth, first equipment, pwc, school entry, scoliosis, recent surgery)*	***At Home***	***At School***	***Transportation***
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Continue completing page 2, and relevant sections on page 3

Present Equipment:	***Date / Year Received:***	***Prescribed by KidsAbility***	
		Yes	*No*
Manual Wheelchair ☐		☐	☐
Power Wheelchair ☐		☐	☐
Stroller ☐		☐	☐
Seating System ☐		☐	☐
Custom seat cushion ☐		☐	☐
Custom molded seating ☐		☐	☐
Vendor Choice *(Please name):*			

Date:	
Name of Client:	
Date of Birth:	

Please check off all factors that apply:	
#1	☐ Palliative (complete top p.3 Questionnaire section on Palliative)
	☐ Acute Pain – intense and intolerable (complete bottom p.3 Questionnaire section on Pain)
	☐ Acute Skin Trauma – redness that lasts 30+ minutes, breakdown, open sore (complete top p.4 Questionnaire section on Skin Trauma)
	☐ No longer able to use current system due to: ☐ pain or discomfort ☐ surgical intervention (able to sit for 2 hours if post-spinal surgery) ☐ newly acquired/revised orthopedic devices
	☐ Safety - Risk of personal injury: ☐ strangulation ☐ falling out of wheelchair ☐ unstable wheelchair (tippy) ☐ Other: _____ (complete bottom p.4 Questionnaire section on Safety)
	☐ Other urgent factor not described above:
#2	☐ Pain, discomfort resulting in decrease in sitting tolerance (complete bottom p.3 Questionnaire section on Pain)
	☐ Redness occurs on a daily basis
	☐ Children with no specialized seating or mobility equipment in place and lack head/trunk control and standard equipment is not meeting needs
	☐ Loss of independent mobility (i.e. could previously walk or could self-propel manual wheelchair but now cannot due to progressive or worsening condition (i.e. MD, SMA) (complete top p.5 Questionnaire section on Loss of Independent Mobility)
	☐ Change in ability to sit upright due to progressive or worsening condition (i.e. MD, SMA)
	☐ Equipment needed for school (school entry, transition to high school)
	☐ Progression of scoliosis (complete bottom p5. And 6. Questionnaire section on Scoliosis)
#3	☐ Growth of client who uses custom fabricated seating (custom mold/cushion)
	☐ Decrease in sitting tolerance due to discomfort
#4	☐ Growth of client resulting in poor positioning in wheelchair
	☐ Client receiving first equipment for distance mobility
#5	☐ Consideration of powered mobility
	☐ Secondary/back-up piece of mobility equipment

Palliative

Questions to ask:		
	What is the diagnosis?	
	How rapidly are changes occurring?	
	What is the prognosis?	
	If prognosis is short, (less than a year) are you thinking of loan or purchase?	☐ Loan ☐ Purchase
	What is the current status?	
	Equipment - current mobility equipment plus any extra to be carried on the wheelchair, i.e. oxygen, feeding pump, ventilator, batteries	
	Mobility	
	Sitting abilities	
	Sitting tolerance	
	Skin condition	
	Other	

Pain

Questions to ask:		
	Where is the pain?	
	Prior to the occurrence of pain, how long can the child tolerate being in the wheelchair?	
	How long can the child be in the wheelchair before the pain occurs?	
	How long can the child tolerate the pain while in the wheelchair?	
	How long does the child need to be out of the chair before the pain goes away and you can put them back in the chair?	
	What do you do to relieve the pain?	
	Have you sought medical attention regarding the pain?	Yes ☐ No ☐
	If yes, from whom?	
	When?	
	What did they say?	

Skin Trauma

Questions to ask:		
	Location of skin trauma. Describe the skin condition.	
	Is there redness?	Yes ☐ No ☐
	If yes, how long before the redness appears?	
	If yes, does this disappear when child is taken out of the wheelchair?	Yes ☐ No ☐
	How long before it disappears?	15 minutes ☐ 30 minutes ☐ More ☐
	Is there an open sore / cuts?	Yes ☐ No ☐
	Is there swelling?	Yes ☐ No ☐
	Have you sought medical attention?	Yes ☐ No ☐
	If yes, from whom?	
	When?	
	What did they say?	

Safety

Questions to ask:		
	Describe what is happening with the wheelchair and/or seating system.	
	Describe the posture or actions of the child that are unsafe to the child or caregiver.	
	Does this happen:	How often:
	At school ☐	
	At home ☐	
	Outdoors ☐	
	During transport ☐	
Consider these safety factors:		Please describe:
	☐ The child is at significant risk for injury:	
	☐ The child's position is compromised:	
	☐ Straps have a potential for strangulation:	
	☐ Is there potential for the child to fall out of the chair?	
	☐ Child or wheelchair is unstable (falling forward or sideways):	
	☐ Displacement/slippage of straps:	
	☐ Risk of wheelchair tipping over:	
	☐ School bus refusing to transport due to safety concerns:	

Loss of Independent Mobility

Questions to ask: Complete Pain, Safety or Scoliosis Questions if relevant	When did you start to notice the changes? How rapidly are the changes occurring? Describe the concerns. ☐ falling/decrease in ability to walk (see next question): ☐ progression of scoliosis: ☐ skin breakdown: ☐ ability to sit upright:
	Is the client able to walk? ☐ Yes ☐ No How far can they walk? What aids are they using for walking? Where is the mobility issue occurring? ☐ Home ☐ School ☐ Community
	Is there a decrease in the ability to safely operate power wheelchair? Describe.
	Is there a decrease in the ability to propel manual wheelchair? Describe.

Scoliosis/Change in Ability to Sit Upright

Questions to ask: Complete Pain, Safety Questions if relevant	What is the concern?	
	Is there an increase in the scoliosis?	
	Is there a change in functional status? (i.e. ability to perform ADL's, use joystick or computer access) Describe.	
	Are they experiencing pain due to:	☐ body brace
		☐ surgery
		☐ skin trauma
		☐ decreased sitting tolerance
	Have they been seen by an orthopedic surgeon?	
	Who?	
	When?	
	What did they say?	
	What is the planned intervention to manage the changes (e.g. body brace, surgery)?	
	When?	
	Monitoring – Next Appointment:	
	Test results, e.g. x-rays?	

Consider these factors which indicate Priority #1:	▪ Can no longer fit in the chair
	▪ Unable to use the chair due to receiving a new or revised body brace
	▪ Seating and mobility system is significantly compromised due to a sudden change in spine due to recent medical intervention, i.e. surgery