KidsAbility™

APPLICATION - SEATING AND MOBILITY SERVICES – EXTERNAL

New referrals only

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:**	

Parent/guardian acknowledgement

☐ I declare that this referral was completed in collaboration with a parent/guardian. The parent/guardian is aware of the referral and has agreed that the information shared is correct.

Name of parent involved:

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

Present Equipment:	**Date / Year Received:**	**Prescribed by KidsAbility**	
		Yes	No
☐ None			
☐ Manual Wheelchair		☐	☐
☐ Power Wheelchair		☐	☐
☐ Stroller		☐	☐
☐ Seating System		☐	☐
☐ Custom seat cushion		☐	☐
☐ Custom molded seating		☐	☐

Vendor Choice

☐ Motion Kitchener	☐ Ontario Home Health
☐ Mobility in Motion (Guelph)	☐ Wilder Medical Home Care Centre
☐ National Home Health Care	☐ Other *(Please name):*

Please check off all factors that apply:	
#1	☐ Palliative
	☐ Acute Pain – intense and intolerable
	☐ Acute Skin Trauma – redness that lasts 30+ minutes, breakdown, open sore
	☐ 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: ____________________
	☐ Other urgent factor not described above:
#2	☐ Pain, discomfort resulting in decrease in sitting tolerance
	☐ 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)
	☐ 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
#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
#6	☐ Non-ADP eligible (eg. Scooter, large youth stroller,)
	☐ Other (Describe):

Please fax referral to 519-886-7292.