

COMPLEX ADULT SEATING CLINIC REFERRAL

Please fax completed referral form to Central Intake 613- 548-5595

THIS DEMOGRAPHIC SECTION <u>MUST</u> BE COMPLETED IN FULL		
Name:		
Street Address:		
City:	Postal Code:	
Home Telephone:	Work Telephone:	
Birthdate: YYYY/MM/DD		
Family or Referring Physician:		
Diagnosis (including conditions, allergies and medications which may affect seating prescription):		
Name of contact person:		Telephone:
Wheelchair	Do you presently have a wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Power Wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/> Other:	
	How long have you had your current device?	
Seating Concerns	Do you have custom seating? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	What are your current seating concerns?	
	<input type="checkbox"/> Pain/Comfort <input type="checkbox"/> Mobility or Function <input type="checkbox"/> Wrong Size <input type="checkbox"/> Postural Deformity	
	<input type="checkbox"/> Posture/Sitting Support <input type="checkbox"/> Condition of current wheelchair	
	<input type="checkbox"/> Pressure Area/Skin Breakdown – if box is checked please answer questions below	
	<input type="checkbox"/> Location of concern <input type="checkbox"/> Right Buttock <input type="checkbox"/> Left Buttock <input type="checkbox"/> Coccyx/Tailbone <input type="checkbox"/> Other:	
	<input type="checkbox"/> Is the area red? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Is there an open wound? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How long has this area of concern been present?		
Goals	What are your goals for this clinic visit?	
	<input type="checkbox"/> New Manual Wheelchair	<input type="checkbox"/> New Power Wheelchair
	<input type="checkbox"/> New Cushion	<input type="checkbox"/> Improved Comfort
	<input type="checkbox"/> Improved Mobility	<input type="checkbox"/> New Back Support
	<input type="checkbox"/> Improved Pressure Reduction	<input type="checkbox"/> Improved Posture
<input type="checkbox"/> Other:		
Are you currently seeing a physiotherapist or occupational therapist? Or, have you seen a therapist in the past for your mobility device? <input type="checkbox"/> Yes <input type="checkbox"/> No		Therapist's Name:
		Agency:
		Telephone:

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Transportation to clinic? <input type="checkbox"/> Personal Vehicle <input type="checkbox"/> Access Bus	
Power of Attorney (POA) for Personal Care (if applicable) or Substitute Decision Maker (SDM)	Name & Relationship:
	Telephone:
Vendor Choice:	
Funding Sources: <input type="checkbox"/> Insurance <input type="checkbox"/> ODSP <input type="checkbox"/> WSIB <input type="checkbox"/> Other:	
Please Note: If you require assistance for providing basic needs while attending clinic, a caregiver must accompany you.	
Date: YYYY/MM/DD	Referring Physician (please print):
Time: HH:MM	Referring Physician (signature):