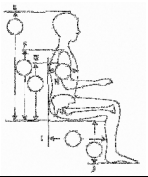
Vancouver CoastalHealth
Promoting wellness. Ensuring care.
G. F. Strong Rehab Centre

SEATING SERVICE REFERRAL FORM

4255 Laurel Street, Vancouver, BC. V5Z 2G9

Fax Referral Form to: 604-730-7904



PLEASE ENSURE BOTH PART ONE AND PART TWO ARE COMPLETED
INCOMPLETE REFERRALS WILL NOT BE PROCESSED AND WILL BE RETURNED

PART ONE

CLIENT INFORMATION

Client Name: (Last, First)	DOB: (dd/mm/yr)	Gender: □ M □ F □ Other
Address: (#, street, city, postal code) Email:	PHN: Contact Telephone #: Alt. Contact if not client: (Name, Relationship, Phone)	
Speaks/Understands English? □ Yes □ Minimal □ No Interpreter: □ No □ Yes (Language) :		

CARE PROVIDER INFORMATION

Referring Physician: _____ Tel.#: Fax #:	Family Physician: _____ Tel #:
Primary Therapist (OT/PT): _____ CHC/Facility: _____ Tel #: _____ Mobile #: _____ Email: _____	

MEDICAL STATUS

Primary Diagnosis: Date of injury/diagnosis: (dd/mm/yr)	Other medical conditions:
Current wounds/skin risk? □ No □ Yes	Braden Score:
Relevant behavior or mental health concerns? □ No □ Yes History of physical/verbal aggression? □ No □ Yes	If yes, please comment:
Relevant medications: (i.e., pain/spasticity)	

MEDICAL EQUIPMENT FUNDING INFORMATION

Is the client covered under the HSCL/CLBC program? □ No □ Yes
Is the injury/diagnosis work or motor vehicle accident related? □ No □ Yes
If yes: □ WorkSafeBC □ ICBC Claim #:

PHYSICAL STATUS

Motor and Sensory Impairment:

Tone/Spasticity:

Skin Integrity/Pressure Injuries: (location, stage, cause, history):

Pain:

Please include any relevant medical history (recent consults, imaging reports, etc.) with referral

Referring Physician / Primary Therapist Signature: **Date:**

PART TWO

INITIAL SEATING AND MOBILITY SCREEN

THIS PORTION TO BE COMPLETED BY PRIMARY THERAPIST

FUNCTIONAL STATUS

Mobility (ambulation, manual/power wheelchair, hand/foot propulsion, drive control method):

Transfers (method, level of assistance, equipment):

ADLs (level of independence):

Support Persons (home care hours):

Environment/Accessibility:

CURRENT MOBILITY EQUIPMENT

Mobility Base (make/model/age):

Cushion (make model/age):

Backrest (make/model/age):

Accessories (trays, guides, straps):

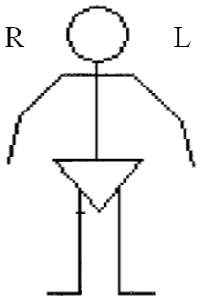
Funder:

Preferred Vendor (rep):

SITTING POSTURE IN WHEELCHAIR

Pelvic Tilt: □ Neutral □ Posterior □ Anterior
Pelvic Obliquity: □ Neutral □ Lower right □ Lower left
Pelvic Rotation: □ Neutral □ Forward right □ Forward left
Trunk Position: □ Midline □ Right lean □ Left lean
Spinal Alignment:
Scoliosis: □ Neutral □ Convex right □ Convex left □ S-curve
Lordosis: (Y or N) Kyphosis: (Y or N); level:
Lower Extremities: □ ABduction □ ADduction
Windsweeping: (Y or N) □ Knees right □ Knees left
Head/Neck position: □ Forward □ Hyperextended □ Side flexed (R or L)

Anterior View:



SEATING AND MOBILITY GOALS

List the client's seating goals or issues affecting current seating and mobility:

1.

2.

3.

SEATING INTERVENTIONS

Please describe recent interventions relating to the seating needs identified on this referral:

Please include any additional relevant assessments or progress notes

Primary Therapist Signature: **Date:**