Seating (Wheelchair) Clinic Pre-Appointment Form

Seating Clinic scheduling line: (816) 234-3380
Rehabilitation Clinic: (816) 234-3970

PARENTS- PLEASE FILL OUT THE FOLLOWING INFORMATION AND BRING THIS FORM WITH YOU TO YOUR CHILD’S APPOINTMENT.

Diagnosis: _____________________________________________________________
Onset of Disability: ______________________________________________________
Goal for Today’s Visit: ____________________________________________________

Mobility Goal: I would like my child to be □ Independent moving the wheelchair at home and at school
□ Independent moving the wheelchair in the community
□ Comfortable sitting in seating system
□ Other: __________________________

Current Medications: ____________________________________________________
Past Surgical History: ____________________________________________________

Any Upcoming Surgeries: □ No □ Yes: __________________________

What do you LIKE about your child’s current chair? __________________________
What do you DISLIKE about your child’s current chair? ________________________

ENVIRONMENT OF USE: my child lives in the following
□ Apartment □ Town House/Duplex □ Single Family Home □ Mobile Home □ Group Home
Are there steps from outside to enter the house?: □ Yes □ No If yes, how many: ______
Are there steps inside the home?: □ Yes □ No If yes, how many: ______
Is there a Ramp to enter home?: □ Yes □ No
Is there a storage Area for Equipment?: □ Yes □ No □ Car □ Garage □ Storage Space □ Living Space

Living Area: Is the Bathroom door wide enough for wheelchair to fit through? □ Yes □ No
Is the Bathroom wheelchair accessible- can your child get to the sink, toilet, shower/tub? □ Yes □ No
Is the Kitchen door wide enough for wheelchair to fit through? □ Yes □ No
Is the Kitchen wheelchair accessible- can your child get to the sink, refrigerator, cabinets? □ Yes □ No

TRANSPORTATION: my child rides in the following (mark all that apply)
Personal: □ Car □ Mini-van □ SUV □ Adapted Van □ Public Transportation
If in Mini van or Adapted van- does the vehicle have tie downs for a wheelchair? □ Yes □ No
School: my child rides to school in the following: □ Bus □ Van □ Parent Transportation
If on bus or van- are there Tie Downs for a wheelchair? □ Yes □ No
What direction does your child face when riding on the bus or van? □ Forward □ Sideways □ Unknown
Do you know of any problems/difficulties with transportation to school? __________________________

DOES YOUR CHILD USE HIS/HER WHEELCHAIR AT SCHOOL? *******If NO- skip to next section*******
SCHOOL: Name of School: __________________________
Building Access:
Is your child’s school level allowing him/her to enter the building?  ☐ Yes  ☐ No
Is there an Elevator in the school to assist him/her to move around the building?:  ☐ Yes  ☐ No
Please list any areas of the school your child cannot access using their wheelchair: __________________________

Mobility: How much assistance does your child need for the following activities? Please check the appropriate box.
To/from Bus:  ☐ Independent- does all by him/herself ☐ Assist from peers ☐ Assist from para/teacher  ☐ Don’t know
To/from Classroom:  ☐ Independent- does all by him/herself ☐ Assist from peers ☐ Assist from para/teacher  ☐ Don’t know
Moving within the Classroom:  ☐ Independent- does all by him/herself ☐ Assist from peers ☐ Assist from para/teacher  ☐ Don’t know
To/from other buildings at school:  ☐ Independent- does all by him/herself ☐ Assist from peers ☐ Assist from para/teacher  ☐ Don’t know

Classroom: Does your child use his/her wheelchair while in the classroom?  ☐ Yes  ☐ No  ☐ Don’t know
If so, does your child’s current wheelchair fit under the desk or table?  ☐ Yes  ☐ No  ☐ Don’t know
Does the current wheelchair allow your child to fully access the school?  ☐ Yes  ☐ No  ☐ Don’t know
Does the school have an evacuation plan that allows your child exit the school quickly in case of fire?  ☐ Yes  ☐ No  ☐ Unknown

SELF CARE:
FEEDING: Does your child have any of the following?
☐ NG Tube  ☐ G-Tube  ☐ Need IV Pole on wheelchair for feedings or medications?

BOWEL and BLADDER:
Does your child wear a diaper for bowel or bladder control?  ☐ Yes  ☐ No
Does your child require catheterization?  ☐ Yes  ☐ No
If yes, does your child perform this activity:  ☐ Independent – does all by him/herself  ☐ Requires some assist
☐ Requires full assist from another person

DRESSING: does your child perform this activity:
☐ Independent – does all by him/herself  ☐ Requires some assist
☐ Requires full assist from another person  ☐ Dependent – requires full assist from another person

TRANSFER IN AND OUT OF WHEELCHAIR
How does your child transfer in/out of the wheelchair?:  ☐ Human Lifter (1 or 2 person)  ☐ Stand Pivot  ☐ Slide  ☐ Mechanical Lift
Is your child able to transfer from the wheelchair to the floor by him/herself?  ☐ Yes  ☐ No
Is your child able to transfer from the wheelchair to the bed by him/herself?  ☐ Yes  ☐ No

MOBILITY Is your child able to do the following: (choose all that apply)
Manual Wheelchair:  ☐ Able to independently move his/her wheelchair in the community for long distances
☐ Able to independently move his/her wheelchair in the community for short distances
☐ Able to independently move his/her wheelchair in the classroom or inside your home
☐ Requires full assist- is pushed in wheelchair

Power Wheelchair (if applicable):  operates the chair using which of the following:
☐ Joy Stick  ☐ Sip and Puff  ☐ Switches: Mounted on the  ☐ Left  ☐ Right

Ambulation: is your child able to do some walking?  ☐ Yes  ☐ No
If YES, please answer the following:
Does he/she use an assistive device?  ☐ Yes  ☐ No
If yes- What type:  ☐ Walker  ☐ Crutches  ☐ Gait Trainer  ☐ Other:________________________

Does he/she use a stander?  ☐ Yes  ☐ No  Type:________________________
How does your child “usually” move around inside your home (ex: crawling, walking):________________________

Please choose what best describes your child’s walking abilities:
☐ Able to walk in the community for short distances with/without assistive device
☐ Able to walk in classroom or at home with/without assistive devices or furniture
☐ Able to stand and use assistive device for transfers
☐ Other:________________________

PARENTS CAN STOP FILLING OUT INFORMATION HERE
CURRENT WHEELCHAIR EXAMINATION (TO BE COMPLETED BY PRACTITIONER)

WHEELCHAIR: Manufacturer: ___________________  Model:____________  Purchase Date: ____/____/____

Problems:  □ Outgrown  □ In Disrepair  □ Provides Insufficient Support  □ Does not accommodate limited ROM
□ Cannot Vary Seat Back angle  □ User Cannot Push Functionally  □ User cannot push at all
□ User does not tolerate  □ Other: ______________________________________________________
□ Not Applicable – this is the patient’s first Wheelchair

SEATING SYSTEM:  Seat:_______________________________________  Purchase Date: __________________________________
Back: ____________________  Purchase Date: _________________________________

Accessories:  □ Head Rest  □ Anterior Trunk Support  □ Lap Belt  □ Lateral Trunk Support  □ Hip Guides  □ Pelvic Well
□ Clothing Guard  □ Lateral Thigh Guides  □ Medial Thigh Guide  □ Shoe Holders  □ Ankle Huggers
□ Foot Straps  □ Upper Extremity Support Surface  □ Other:______________________________

Problems:  □ Outgrown  □ In Disrepair  □ Provides Insufficient Support  □ Does not accommodate limited ROM
□ Cannot Vary Seat Back angle  □ User Cannot Push Functionally  □ User cannot push at all  □ User does not tolerate
□ Other: ______________________________________________________
□ Not Applicable – this is the patient’s first Wheelchair

REVIEW OF SYSTEMS

□ Neurological/Seizures  Frequency:__________________________  Medication:_____________________________________
□ Cardiac:________________________________________________
□ Pulmonary  □ Bi-Pap, □ C-Pap, □ Ventilator, □ Tracheostomy, □ Asthma  □ Other:_____________________________
□ Vision:___________________________________________________
□ Hearing:__________________________________________________
□ Gastrointestinal____________________________________________
□ Skin: any history of breakdown or sores? □ Yes  □ No ________________________________
□ Allergies:___________________________________________________
□ Other:_____________________________________________________

NEEDS ASSESSMENT

Cultural/Religious Practices: □ None  □ Yes:_______________________________
Emotional/Family/Home Concerns: □ None  □ Yes:_______________________________
Barriers to Learning: □ None  □ Vision  □ Hearing  □ Reading  □ Language  □ Learning Disability  □ Other:___________________
Learning Needs Identified □ None  □ Yes:_______________________________
Translator Present For: □ Not Applicable  □ Whole Session  □ Interview  □ Exam  □ Instructions
Immunizations Up-to-Date: □ Yes  □ Unknown  □ No, explain:_____________________

Pain Assessment: Is there pain now □ No  □ Yes:  Pain Scale Used: □ VAS  □ FLACC  □ FACES  Pain Rating__________
Informant: □ Patient  □ Parent/Caregiver  □ Other:_______________________________

PHYSICAL EXAMINATION (TO BE COMPLETED BY PRACTITIONER)

Height:_______cm  Weight:_______kg

SITTING BALANCE
□ Dependent requiring external support  □ Propped with hand support  □ Hands free, no weight shifting
□ Hands Free with ability to weight shift  □ Sits independently for < 5 minutes  □ Sits independently for > 5 minutes

HEAD CONTROL:
□ Good: Can hold head in midline  □ Fair: hold head in midline for less than 2 minutes  □ Poor: Dependent for head in midline
SITTING POSTURE

- Posterior Pelvic Tilt: □ Fixed  □ Flexible
- Anterior Pelvic Tilt: □ Fixed  □ Flexible
- Pelvic Obliquity (□ R □ L): □ Fixed  □ Flexible
- Pelvic Rotation Protracted (□ R □ L): □ Fixed  □ Flexible
- Neck Hyperextension: □ Fixed  □ Flexible
- Leg Abduction: □ Fixed  □ Flexible
- Leg Adduction: □ Fixed  □ Flexible
- Wind Sweeping: □ Fixed  □ Flexible
- Shoulder Elevation (□ R □ L): □ Fixed  □ Flexible
- Unequal Weightbearing: □ > R □ > L
- Leg Length Discrepancy: □ > R □ > L
- Scoliosis (Primary Convex □ R □ L): □ Fixed  □ Flexible
- Forward Head: □ Fixed  □ Flexible
- Other: __________________________

TONAL INFLUENCES/REFLEXES

- Extensor Tone: □ RUE □ LUE □ RLE □ LLE
- Flexor Tone: □ RUE □ LUE □ RLE □ LLE
- Asymmetrical Tonic Neck Reflex: □ Symmetrical Tonic Neck Reflex
- Ankle Clonus: □ Right □ Left □ Positive Support
- Other: ______________________________________

RANGE OF MOTION

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<td>Hamstring Length</td>
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<td>Ankle Dorsiflexion</td>
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<td>Shoulder Elevation</td>
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<td>Elbow Flexion</td>
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<td>Patient is able to activate: □ communication device □ switches □ computer</td>
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SKIN BREAKDOWN

- Decreased Sensation: □ Yes – Level: ____________ □ No
- Areas of Breakdown: □ Ischial Tuberosity □ Coccyx □ Spinal Process □ Other: __________________________

BRACING

- Ankle Foot Orthosis □ TLSO □ Other LE Extremity Bracing: __________________________
- Upper Extremity Bracing: ________________________________________________
WHEELCHAIR PRESCRIPTION:

| ARM POSITIONING |  □ None  □ Tubular  □ Arm Pads  □ Full Length  □ Desk  □ Trough  □ Adjustable Height  □ Removable Flip Away  □ Swing Away  □ Upper Extremity Support Surface  □ Other:______________________________ |
| FOOT POSITIONING |  □ Swing Away  □ Platform  □ Adjustable Angle  □ Rigid  □ Shoe Holders  □ Ankle Huggers  □ Foot Straps  □ Foot Hangers (____)  □ Anterior Calf Strap  □ Posterior Calf Strap  □ Heel Loops  □ Padded foot box  □ Custom Foam  □ Other:______________________________ |
| SEAT |  □ Custom Foam/Physiologic Contour  □ Pressure Relieving (□ Roho, □ Jay, □ Stimulite) □ Ride  □ Silhouette Contour-U □ Pressure Mapping □ Medial Thigh Guide □ Hip Guides □ Lateral Thigh Guides □ Lateral Knee pads □ Pelvic Well □ Clothing Guard □ Special Features/Other:______________________________ |
| BACK |  □ Custom Foam  □ Jay  □ Ride  □ Easy Conforming  □ I-Back  □ T-Back  □ Adjustable Tension  □ CorBac Swing Away Trunk Laterals □ Gentle curve □ Depth Adjustable  □ Other:______________________________ |
| HEAD REST/SUPPORT |  □ 1-Piece Curved □ 3-Piece □ Extended □ Contoured Cradle □ Whitmeyer □ Stealth □ I-2-I □ Hensinger Custom: ____________________________ □ Other:______________________________ |
| RESTRAINT SYSTEM |  □ Padded Pelvic Belt, Proximal Femur □ Strap guides □ Anterior Trunk harness □ Horizontal chest strap Special Features/Other:______________________________ |
| TIRES |  □ Flat Free □ KIK □ Pneumatic □ Push Tires-Size:_______ □ Casters. Size_______ □ Special Features/Other:______________________________ |
| WHEELS |  □ Spoke □ Guards □ Mags □ Camber  □ Standard □ Scissor □ Extensions □ Foot □ High Mount □ Low Mount □ Hub Lock |
| OTHER EQUIPMENT |  □ Anti Tips □ Push Canes □ Adjustable □ Crutch holder □ Stroller Extensions □ All Necessary brackets and Hardware □ Medical necessities Bag □ Vent Tray □ Oxygen Tank Holder □ IV Pole □ Other:______________________________ |

REASONS FOR MEDICAL NECESSITY

- □ Independent Mobility  □ Meet Caregiver Goals  □ Accommodate Deformity  □ Accommodate Tonal Influences  □ Pain Relief  □ Safety for Feeding/Swallowing  □ Improve Appearance  □ Improve Head Position/Visual Field  □ Pressure Relief  □ Accommodate Joint Limitations  □ Increase Sitting Tolerance  □ Meet Transportation Need  □ Improve Posture  □ Allow for Growth/Weight Gain  □ Dependent Mobility  □ Meet Vocational/School Needs  □ Endurance  □ Adjustable for Medical Problems (i.e. seizures, suction):______________________________  □ Improve Functional Level  □ Community integration  □ Other:______________________________  □ Accommodate Functional Level  □ Community integration  □ Other:______________________________ |

TEAM SIGNATURES

Physician: ___________________________  Printed Name  Signature  3/3/2023

Therapist Evaluator: ___________________________  Printed Name  Signature  3/3/2023

Parent/Guardian/Chair User: ___________________________  Printed Name  Signature  3/3/2023

Rehabilitation Technology Supplier: ___________________________  Company  Printed Name  Signature  3/3/2023