Health Sciences Centre
Winnipeg

Assistive Technology
Occupational Therapy

Initial Mobility Screen*

Client name:

Power mobility issues identified by the client, therapist, and/or caregivers to be addressed through referral to Assistive Technology:

To understand your client better, please answer the following questions:

1. What type of wheelchair does the client currently use?

MOBILITY BASE	**SEATING COMPONENTS**	
(check all that apply)	Cushion	Backrest
☐ Manual folding frame ☐ Manual rigid frame ☐ Manual positioning frame (i.e. tilt & recline) ☐ Power rear wheel drive base ☐ Power mid wheel drive base ☐ Power positioning base ☐ Other	- Make and model of cushion: - Dimensions: - Age of cushion: - Supplier: ☐Upholstery only	- Make and model of backrest: - Dimensions: - Age of backrest: - Supplier: ☐Upholstery only
Primary Wheelchair Used ☐ Manual ☐ Power - Make and model of mobility base: - Age of mobility base: - Supplier:	**----------**	----------
	Height of client: _____	**Weight of client:** _____

*This form should be completed by the primary therapist and accompany the "***Assistive Technology Products and Services Referral Form***"*

2. Do the current seating components (i.e. cushion/backrest) need to be reassessed? _____ If yes, please state reason.

3. What is the client's current sitting tolerance in primary wheelchair?

4. Does client need to be assessed for power mobility driving options (i.e. first time driver) or be re-assessed for alternative driving options?

5. When was the last time that the client drove their power wheelchair?

6. If the client is not driving the power wheelchair, please state reason.

7. Does your client have a pressure sore? _____ If yes, please specify size & location.

8. Is this client is too complex for you to deal with the presenting problem? Please state reason.

9. Please provide the following environmental information:

Physical environment:	Transportation:	Accessibility concerns (check all that apply & specify):
☐ Home/condo	☐ Driver	☐ Doorways/Entrances
☐ Apartment	☐ Passenger	
☐ Assisted living		
☐ Personal Care Home	Transportation Method:	☐ Ground surfaces
☐ Other:_____	☐ Car	
	☐ Van	☐ Turning spaces
Social Environment:	☐ Bus	
☐ Lives alone	☐Other:_____	☐ Knee clearance
☐ Lives with others	Transportation Equipment:	
☐ Provides care to others	☐Ramp	☐ Head clearance
☐ Receives care from others	☐Lift	
☐Other: _____	☐Other:_____	☐ Other:_____

10. Please provide information on the client's functional performance:

Mobility Status		
Transfer Method	Primary Mobility	Repositioning Ability
☐ Independent	☐ Dependent	☐ Independent

*****This form should be completed by the primary therapist and accompany the "***Assistive Technology Products and Services Referral Form***"

Transfer Method	Primary Mobility	Repositioning Ability
☐ Assisted **(please specify below):** ☐Mechanical lift with sling ☐Manual lift ☐Sliding board ☐Pivot ☐ Other: _____	**OR check all that apply**: ☐ Manual arm propulsion ☐ Manual foot propulsion ☐ Joystick power driving ☐ Alternative power driving ☐ Other: _____	☐ Assisted (**Check all that apply)**: ☐ Arm push ups ☐ Side leaning ☐ Forward leaning ☐ Tilt in space ☐ Other: _____
Continence Issues	**Activities of Daily Living (ADL)**	**Productivity and Leisure**
☐Continent of both bladder & bowel ☐ Bladder incontinence ☐ Bowel incontinence **Incontinence management:**____ _____ _____	☐ Independent with self care tasks ☐ Assistance for self care tasks **Care provider and hours:**_____ _____ _____ _____ _____	☐ Paid work ☐ Volunteering ☐ School ☐ Leisure/social outings **Hours per day of productivity or leisure tasks: ___ hrs/day**

Please attach photographs of the client in the seating system
or send digitals photos via e-mail to cnixdorf@hsc.mb.ca

☐ Front view ☐ Side View ☐ Rear View

Form Completed By (please print name & provide your professional designation):

_____

Date completed: _____

*****This form should be completed by the primary therapist and accompany the
*"**Assistive Technology Products and Services Referral Form"***