SPECIALIZED SEATING SERVICE (SSS)
Intake Referral Form

REFERRAL CRITERIA (please check all that apply)

☐ 18 years of age
☐ Residence in Manitoba or Nunavut
☐ Neurological diagnosis
☐ Full-time wheelchair user
☐ Primary therapist assigned

CLIENT HEALTH & DEMOGRAPHIC INFORMATION

Client Name:	**Date of Birth** (day / month / year):	**Phone Number:**	**MHSC Number:** **PHIN Number:**
Address:	**Postal Code:**	**Client Height:**	**Client Weight:** Stable? Yes ☐ No ☐
Diagnosis: ☐ Date of onset ☐ Progressive condition	**Secondary Medical Conditions:**	**Surgical History:** ☐ Flap surgery ☐ Hardware/instrumentation ☐ Other: specify	**Medications:** ☐ Anti-spasticity ☐ Botox ☐ Pain (neurogenic or other) ☐ Other
Primary Contact Person: Name: Relationship: Phone: Fax: e-mail:	**Referring Therapist:** Name: Address: Phone: Fax: e-mail:	**Physician:** Name: Address: Phone: Fax: e-mail:	**Has the client ever had a seating assessment?** Yes ☐ No ☐ If Yes: When? Where?
Funding Source(s) for Seating Equipment:			
☐ **Insurance company** Name: Policy Number: Case Manager: Phone:	☐ **Employment and Income Assistance (EIA)** Case worker: Phone: Fax: File Number:	☐ **Non-Insured Health Benefits (NIHB)** Treaty Number: Band name:	☐ **Self** ☐ **Other: specify**

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☐ Picture of client in mobility base – front view

☐ Picture of client in mobility base – side view

☐ Picture of client in mobility base – rear view

SSS CLINICAL REFERRAL CATEGORIES
√ CHECK ALL THAT APPLY

☐ Pressure Management

☐ Existing wound(s) on sitting surface

Location:
Stage:
Duration:
Cause (if known):

Location:
Stage:
Duration:
Cause (if known):

☐ Previous wound(s) on sitting surface

Location:
Stage:
Duration:
Cause (if known):

Location:
Stage:
Duration:
Cause (if known):

☐ Heat and moisture issues

☐ Limited sitting tolerance

☐ Bedrest/unsafe to sit

☐ Postural Management

☐ Postural asymmetry (in pelvis or spine)

☐ Decreased balance

☐ Sliding

☐ Leaning

☐ Loss of position in chair (moving away from positioning supports)

☐ Falls or safety issues related to positioning loss

☐ Low back pain

☐ Neck pain

☐ Limited sitting tolerance

☐ Abnormal tone/spasticity

☐ Functional Mobility

☐ Shoulder pain impacting wheeled mobility

☐ Loss of independent mobility

☐ Difficulty maneuvering manual wheelchair

☐ Difficulty maneuvering power wheelchair

☐ Assistive Technology Access

☐ Loss of independence or safety concerns related to power mobility driving

☐ Alternative drive control and switch access

Please identify any other seating/mobility concerns not listed above

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WHEELCHAIR EQUIPMENT INFORMATION

Mobility Base (Wheelchair)

(please check all that apply):

- ☐ manual folding frame
- ☐ manual rigid frame
- ☐ manual positioning frame
- ☐ power rear wheel drive base
- ☐ power mid wheel drive base
- ☐ power front wheel drive base
- ☐ power positioning base

Primary wheelchair used:

☐ Manual ☐ Power ☐ Both (50/50 use)

Manufacturer of mobility base(s): _____ **Model(s):** _____

Age of mobility base(s) : _____ **Supplier(s):** _____

What is the current condition of client's mobility base(s)?

- ☐ in good condition
- ☐ requires modifications or repairs
- ☐ requires replacement
- ☐ requires re-evaluation
- ☐ other: _____

Cushion:

- ☐ Commercial product
- ☐ Custom modifications to commercial product
- ☐ Custom product

Manufacturer of cushion: _____ **Model:** _____

Age of cushion: _____ **Supplier:** _____

What is the current condition of client's cushion?

- ☐ in good condition
- ☐ requires modifications or repairs
- ☐ requires replacement
- ☐ requires re-evaluation

Backrest:

- ☐ upholstery only
- ☐ Commercial product
- ☐ Custom modifications to commercial product
- ☐ Custom product

Manufacturer of backrest: _____ **Model:** _____

Age of backrest: _____ **Supplier:** _____

What is the current condition of client's backrest?

- ☐ in good condition
- ☐ requires modifications or repairs
- ☐ requires replacement
- ☐ requires re-evaluation

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