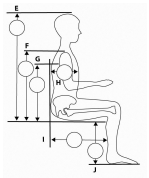
Vancouver CoastalHealth
Promoting wellness. Ensuring care.

G. F. Strong Rehab Centre

COMPLEX SEATING AND MOBILITY SERVICE REFERRAL FORM

4255 Laurel Street, Vancouver, BC. V5Z 2G9

Fax 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

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

MEDICAL STATUS

Primary Diagnosis: Date of injury/diagnosis: (dd/mm/yr)	Other medical conditions:
Current wounds /skin risk? □ No □ Yes 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

Upper Extremity Function:

Tone/Spasticity:

Skin Integrity/ Pressure Injuries: (location, stage, acute, chronic):

Pain:

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

Referring Physician /NP/ Primary Therapist Signature: Date:

PART TWO

SEATING PRE-ASSESSMENT INFORMATION

THIS PORTION TO BE COMPLETED BY PRIMARY THERAPIST

FUNCTIONAL STATUS

Transfers (method, level of assistance, equipment):

Mobility (manual/power wheelchair, ambulation):

ADL's (level of independence):

Support Persons (home care hours):

CURRENT MOBILITY EQUIPMENT

Mobility Base (make/model/age):

Cushion (make model/age):

Backrest (make/model/age):

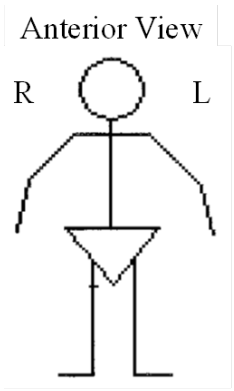
Accessories (trays, guides, straps):

Funder:

Preferred Vendor (rep):

SITTING POSTURE IN WHEELCHAIR

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



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:**