METRO HEALTH SERVICES
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To assist us in obtaining a comprehensive picture of your seating equipment needs, please complete the following questionnaire:

Date of completion of this questionnaire: _____

Person completing questionnaire: _____

Name of client: _____

Address: _____

_____

Age: _____ Date of birth: _____

Person to Contact: _____ Phone #:

Medicare # : _____

Diagnosis (if relevant): _____

Physician: _____

Referral source (if different from above): _____

Therapist(s) involved with client (if relevant):

Name: _____ Workplace: _____ Position:

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Client=s Functional Status

Please place a check in the appropriate column to indicate client=s ability to complete basic self-care needs, according to the following scale:

I= Independent in all aspects of this activity
A= Requires some help or assistance
D= Dependent in all aspects of this activity

Please comment when appropriate or define any equipment used.

	I	A	D	Comments
Dressing				
Feeding				
Bathing				
Toileting				
Transfers				
Mobility				
--walking				
--wheelchair propulsion				

What is the client presently using for a seating system?

___1. No system used
___2. Standard wheelchair; Name brand if possible
___3. Standard wheelchair with insert; Brand if possible
___4. Electric wheelchair
___5. Electric wheelchair with insert
___6. Stroller or Buggy ie: MacLaren Buggy or Infant Stroller
___7. Other - please specify

How long ago did the client begin using a seating system:

___ This is client=s first system

___ An alternate system(s) has been used for ____ years

How long has client been using his/her present seating system: _____ years

Who or which facility prescribed this system (if possible)?

Please indicate any funding services you are associated with which may provide a funding source for this equipment. Please check:

___ Private insurance: Insurance name _____ ID#

___ CRCD

___ Community based services for special needs: Case manager

___ MD Association

___ Income Assistance (DHRD) Health Card #

___ DVA TAPS # K

___ Seniors equipment - Red Cross

___ Other

Relevant Medical Information

Please check and comment if necessary if client has any of the following conditions:

___ 1. Seizures
___ 2. Diabetes
___ 3. Scoliosis
___ 4. Peripheral Vascular Disease
___ 5. Decubitus Ulcers (Bed/Pressure sores) - where?
___ 6. Arthritic conditions
___ 7. Other

Is client booked for surgery, or is surgery being considered in the near future?
No
Yes___ Please specify

Does client wear braces or orthotic devices? Yes___ No
If yes, please specify:

Client attends:

___ School
___ Involved in sports
___ Community outings
___ Regular employment
___ Other

Transportation Systems Used:

___ School bus
___ Community transportation - specify
___ Private vehicle - specify type
Other :_____

Home Accessibility

Client=s home is accessible to a mobility device in the following ways:

1. Ramp Yes ___ No
2. Wide doorways Yes ___ No
3. All rooms accessible Yes ___ No
4. Rooms not accessible:
   Kitchen ___ Bedroom
   Bathroom ___ Other
5. Outdoor surfaces
   ___ Smooth sidewalks
   ___ Rough terrain
   ___ System rarely used sidewalks
   ___ Other

During the seating assessment, it is necessary that the client be transferred from the present seating system to a bed, to check the mobility in all body joints. To help us prepare for the clients assessment, please indicate any equipment we may need for this transfer process.

___ Hoyer lift
___ Transfer (sliding) board
___ One person to assist
___ Two people to assist
___ Client can transfer independently

In order that we may have appropriate demo equipment on hand during the assessment, please indicate the type of seating system the client is hoping to obtain:

___ Manual wheelchair
___ Electric wheelchair
___ Uncertain of the type of system, and would like advice on the appropriateness of either type
___ Other

When the client comes for the assessment, they are to bring their present seating system. This is crucial in gaining an accurate picture of the seating needs. If unable to bring this system, please indicate below, so we may assist you in making arrangements:

___ Yes, client can bring present system
___ No, client cannot arrange transportation for present system
___ Unable to travel to Metro Health Services for the assessment and requires an in-home visit from the Seating Team.

Thank you for the time you have taken to complete this questionnaire. This information will assist us in preparing for the visit and allow us to complete our assessment as quickly and accurately as possible. On the day of the assessment, we ask that you wear comfortable clothes which are easy to move in. The initial assessment will take approximately 2 hours. We will contact you to book an appointment once we receive this completed questionnaire. Please mail to the address on page 1, or drop it off at our office on Level 0 in the Saint John Regional Hospital. If you have any questions, please feel free to contact either Faye or Lisa at 648-6150. We look forward to seeing you in the near future.

The Seating Team at Metro Health Services Inc.