St. Joseph's Health Care London
Parkwood Seating Program
PO Box 5777, STN B,
London ON N6A 4V2
(519) 685-4292, ext. 42199
FAX (519) 685-4560

Referral Source	Service Avenue

Parkwood Seating Program Pre-Assessment Form

Date Reviewed: _____ **Reviewed by:** _____ **CERNER Coding** _____

THIS DEMOGRAPHIC SECTION MUST BE COMPLETED IN FULL

Name	
Street Address	
City	**Postal Code**
Home Telephone	**Work Telephone**
Health Card Number	**Birthdate**
Family or Referral Doctor	
Diagnosis	
Name of Contact Person	**Telephone**

Wheelchair

Do you presently have a wheelchair?

☐ Manual Wheelchair ☐ Power Wheelchair ☐ Other (describe)_____

☐ Tilt ☐Recline ☐ Elevating leg supports

How long have you had your current wheelchair?

Concerns

What are your current concerns related to your wheelchair and/or seating?

☐ Pain/Comfort	☐ Mobility
☐ Posture/Positioning/Sitting Support	☐ Condition of Current Wheelchair/Seating
☐ change in medical/functional condition	☐ need for alternative way to drive a power wheelchair

☐ Other (describe)_____

Skin

Skin Breakdown or Wound(s) ☐ YES **if YES please answer questions below** **☐ NO**

Location of concern ☐ right buttock ☐ left buttock ☐ coccyx/tailbone ☐ other_____

Is the area red? ☐ Yes ☐ No	Is there an open wound? ☐ Yes ☐ No

How long has this skin breakdown or wound(s) been present?

Do you require a dressing/bandage/covering for skin breakdown or wound(s)?
☐ Yes ☐ No

Does nursing provide care and/or monitoring of your skin breakdown or wound(s)
☐ Yes ☐ No

Do you use an augmentative communication device? ☐ Yes ☐ No	Have you been seen at an Augmentative Communication Clinic in the past 5 years? ☐ Yes ☐ No

Have you been seen at the Thames Valley Children's Centre Seating and Mobility Service (SAMS) in the past 5 years?

☐ Yes ☐ No

Are you currently seeing a physiotherapist or occupational therapist? ☐ Yes ☐ No	Therapist's Name	
	Agency	Telephone

Transportation to clinic? ☐ Personal Vehicle ☐ Paratransit ☐ Ambulance

Power of Attorney for Personal Care (if applicable) or Substitute Decision Maker	Name & Relationship
	Telephone
Power of Attorney for Finances (if applicable)	Name & Relationship
	Telephone

Vendor Choice

Goals

What are your goals for this clinic visit? (Specify)	
☐ New manual wheelchair	☐ New power wheelchair
☐ New seat cushion	☐ New back support
☐ Improved mobility	☐ Improved comfort
☐ Adjustments/modifications to wheelchair	☐ Adjustments/modifications to seating
☐ Reduced skin problems	☐ Other (describe)

Please Note:
If you require assistance for providing basic needs while attending clinic, a caregiver must accompany you.

Signature	**Date**
If signature is other than client, please identify relationship.	