Eastern Health

# Adult Postural Seating Clinic Referral

Phone: 777 -6171 / Fax: 777 -6725

Name:

HCN:

Date of Birth:

***The Seating Clinic is not responsible for booking accommodations, travel to/from St John's, or for local transportation. Nor is the Seating Clinic responsible to provide the client's medical or personal care needs while attending the clinic.***

Full Mailing Address: _____

_____

Caregiver's Name:_____ Telephone:_____

Diagnosis: _____

Relevant past medical history (for example, hip dislocation, skin breakdown, etc.)_____

_____

_____

**Presently using:** ☐ manual wheelchair ☐ power wheelchair ☐ stroller ☐ has **NO** wheelchair or stroller

**Condition of the present wheelchair or stroller:** ☐ good condition ☐ adequate for the short term, ☐ requires replacement but still appropriate for client to use ☐ adequate for the short term, but no longer appropriate for client ☐ broken parts but still safe to use ☐ broken parts and a safety hazard to use ☐ not useable at all / dealer identified wheelchair is not repairable

Reason(s) for referral: _____

_____

_____

_____

_____

_____

**Please tick off statements if appropriate:**

☐ Client has a new pressure sore

☐ Client has a chronic pressure sore

☐ Client has fallen out of w/c due to ill fitting insert or w/c being now inappropriate.

**Client is eligible for funding from: (tick off all that are appropriate)**

☐ Special Assistance Program ☐ Insurance: if so, is funding to run out within 12 months? ☐ Yes ☐ No

☐ Other: (specify)_____

How much notice does the client need, to accept an appointment?_____

If the client is an inpatient: where_____

If the client resides further away than the St John's Metro area: Is client able to come to seating clinic? ☐ Yes ☐ No

If no, is referral source requesting ☐ telehealth or ☐ long distance consult only

Client/caregiver is aware of this referral: ☐ Yes ☐ No

Referral source:_____

Signature:_____ Date:_____DD/MONTH/YYYY_____

Telephone:_____ Fax:_____