

P.O. BOX 2415
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1-800-661-1993

OCCUPATIONAL THERAPY SERVICES

Wheelchair Assessment

- Initial Assessment
 Re-Assessment/Follow-up

Please print clearly or type.

			WCB Claim Number	Date of Accident (yyyy/mm/dd)
Worker's Surname	First Name	Initial	Date of Birth (yyyy/mm/dd)	
Address Street	City/Town	Province	Postal Code	Telephone Number ()
Referral Source Name		Referral Source Contact Telephone Number ()		Referral Date (yyyy/mm/dd)
Provider Contact Name		Provider Contact Telephone Number ()		Assessment Date (yyyy/mm/dd)

ASSESSMENT SUMMARY

Referral Question

Location of Assessment

- Home Vendor

Type of Residence

- Own Rental

Person(s) Present During Assessment

Pertinent Architectural Features of Home/Work/Surroundings

Diagnosis/Medical Prognosis/ Hx (diabetes, pressure sores)

Psychosocial/Mental Hx

Current Functional Limitations

- | | | | | | |
|------------------------------------|----------------------------------|-----------------------------------|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Strength | <input type="checkbox"/> Balance | <input type="checkbox"/> SOB | <input type="checkbox"/> Vision | <input type="checkbox"/> Circulation | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Endurance | <input type="checkbox"/> Hearing | <input type="checkbox"/> Edema | <input type="checkbox"/> Perception | <input type="checkbox"/> Pain | <input type="checkbox"/> Coordination |
| <input type="checkbox"/> Sensation | <input type="checkbox"/> Tone | <input type="checkbox"/> Mobility | <input type="checkbox"/> ROM | <input type="checkbox"/> Speech/Communication | |
- Other, please specify:

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Worker's Surname	First Name	<i>(Initial)</i>	Claim Number
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Expected Functional Abilities (If different than above)

Activities Pursued (work, leisure, home)

Transportation (public, van, car)

Will the Worker's Vehicle, Home, and Workplace Accommodate the New Wheelchair?

Other Comments

Plan/Recommendation

Worker's Surname	First Name	(Initial)	Claim Number
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Measurements		Home/Work Environment													
Height:	Weight:	Doorway width:	Front: Rear:												
Hip to hip:	Hip to popliteal:	Bathroom:	Bedroom:												
Elbow to seat:	Axilla to seat:	Main entrance:													
Thigh to bottom of heel:		Hallways:													
<p align="center">Use of Wheelchair</p> <input type="checkbox"/> Independent <input type="checkbox"/> Work <input type="checkbox"/> Daily <input type="checkbox"/> Attendant <input type="checkbox"/> Social/Leisure only <input type="checkbox"/> Other:		<p align="center">Flooring</p> <table border="0"> <tr> <td><u>Home</u></td> <td><u>Work</u></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Carpet</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hardwood</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other:</td> </tr> </table>		<u>Home</u>	<u>Work</u>		<input type="checkbox"/>	<input type="checkbox"/>	Carpet	<input type="checkbox"/>	<input type="checkbox"/>	Hardwood	<input type="checkbox"/>	<input type="checkbox"/>	Other:
<u>Home</u>	<u>Work</u>														
<input type="checkbox"/>	<input type="checkbox"/>	Carpet													
<input type="checkbox"/>	<input type="checkbox"/>	Hardwood													
<input type="checkbox"/>	<input type="checkbox"/>	Other:													
<p align="center">Present Wheelchair(s)</p> <table border="0"> <tr> <td align="center"><u>Primary</u></td> <td align="center"><u>Secondary</u></td> </tr> <tr> <td>Model:</td> <td>Model:</td> </tr> <tr> <td>Serial #:</td> <td>Serial #:</td> </tr> <tr> <td>Age/Yr. Purchased:</td> <td>Age/Yr Purchased:</td> </tr> <tr> <td>Condition:</td> <td>Condition:</td> </tr> </table>		<u>Primary</u>	<u>Secondary</u>	Model:	Model:	Serial #:	Serial #:	Age/Yr. Purchased:	Age/Yr Purchased:	Condition:	Condition:	<p align="center">Outdoor Terrain</p> <input type="checkbox"/> Pavement <input type="checkbox"/> Grass <input type="checkbox"/> Sand/Gravel <input type="checkbox"/> Other:			
<u>Primary</u>	<u>Secondary</u>														
Model:	Model:														
Serial #:	Serial #:														
Age/Yr. Purchased:	Age/Yr Purchased:														
Condition:	Condition:														
<p align="center">Wheelchair Requested</p> Model: Make:		<p align="center">Casters</p> Solid: <input type="checkbox"/> 5" <input type="checkbox"/> 8" Pneumatic: <input type="checkbox"/> 8" x 1¼" <input type="checkbox"/> 8" x 2" Other:													
		<p align="center">Front Rigging</p> <input type="checkbox"/> Swing detachable <input type="checkbox"/> Elevating <input type="checkbox"/> Other													
<p align="center">Wheelchair Specifications</p> Seat Width: <input type="checkbox"/> 16" <input type="checkbox"/> 18" <input type="checkbox"/> Other Seat Depth: <input type="checkbox"/> Standard <input type="checkbox"/> Other Seat Height: <input type="checkbox"/> Standard <input type="checkbox"/> Hemi <input type="checkbox"/> Other Back Height: <input type="checkbox"/> Standard <input type="checkbox"/> Other Back Type: <input type="checkbox"/> Standard <input type="checkbox"/> Reclining <input type="checkbox"/> Other Arm Rest: <input type="checkbox"/> Full Length <input type="checkbox"/> Desk Length <input type="checkbox"/> Wrap-around <input type="checkbox"/> Adjustable <input type="checkbox"/> Other Head Rest: <input type="checkbox"/> Yes <input type="checkbox"/> No		<p align="center">Type of Wheelchair</p> Rim Projections: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: Rim Covers: <input type="checkbox"/> Yes <input type="checkbox"/> No Extra Rim Space: <input type="checkbox"/> Yes <input type="checkbox"/> No Spoke Guard: <input type="checkbox"/> Yes <input type="checkbox"/> No Seat Belt: <input type="checkbox"/> Auto <input type="checkbox"/> Velcro Anti-tipping Device: <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Amputee Adapter <input type="checkbox"/> Heel Loops <input type="checkbox"/> H-Straps <input type="checkbox"/> Light Wt <input type="checkbox"/> Standard Wt <input type="checkbox"/> Heavy Duty <input type="checkbox"/> Active Duty Lt. Wt. <input type="checkbox"/> Other:													
<p align="center">Tires</p> <input type="checkbox"/> Pneumatic <input type="checkbox"/> Solid Rubber <input type="checkbox"/> Spoked <input type="checkbox"/> Treaded <input type="checkbox"/> Smooth <input type="checkbox"/> Poly <input type="checkbox"/> Size 22" <input type="checkbox"/> Size 24" <input type="checkbox"/> Mag <input type="checkbox"/> Quick Release Axle <input type="checkbox"/> Off-set Axle		<p align="center">Wheelchair Cushion</p> Type: Size: Cover: <input type="checkbox"/> Cloth <input type="checkbox"/> Vinyl <input type="checkbox"/> Other Refer to seating clinic: <input type="checkbox"/>													

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Critical Measurements

Width of widest wheelchair used:

Length (back of wheelchair to tip of shoes):

Height (floor to crown of head):

Wheelchair weight:

Worker's weight:

Assessed by:

Phone number:

Date of assessment:

(yyyy/mm/dd)

Wheelchair trials completed: Yes No

Models trialed:

Length of trial:

Trial vendor's name:

Address:

Follow-up date:

Recommended re-assessment date:

Additional Comments

If you have any questions regarding the information or would like to discuss, please contact the undersigned.

Provider's Name

()

Contact Telephone Number

Date (yyyy/mm/dd)