Providence Care

PERSONAL HEALTH INFORMATION

COMPLEX ADULT SEATING CLINIC REFERRAL

Please fax completed referral form to Central Intake 613- 548-5595

THIS DEMOGRAPHIC SECTION MUST BE COMPLETED IN FULL			
Name:			
Street Address:			
City:		Postal Code:	
Home Telephone:		Work Telephone:	
Birthdate: YYYY/MM/DD			
Family or Referring Physician:			
Diagnosis (including conditions, allergies and medications which may affect seating prescription):			
Name of contact person:		Telephone:	
Wheelchair	Do you presently have a wheelchair? ☐ Yes ☐ No		
	☐ Manual Wheelchair ☐ Power Wheelchair ☐ Scooter ☐ Other:		
	How long have you had your current device?		
Seating Concerns	Do you have custom seating? ☐ Yes ☐ No		
	What are your current seating concerns?		
	☐ Pain/Comfort ☐ Mobility or Function ☐ Wrong Size ☐ Postural Deformity		
	☐ Posture/Sitting Support ☐ Condition of current wheelchair		
	☐ Pressure Area/Skin Breakdown – if box is checked please answer questions below		
	☐ 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 area of concern been present?		
Goals	What are your goals for this clinic visit?		
	☐ New Manual Wheelchair	☐ New Power Wheelchair	
	☐ New Cushion	☐ Improved Comfort	
	☐ Improved Mobility	☐ New Back Support	
	☐ Improved Pressure Reduction	☐ Improved Posture	
	☐ Other:		
Are you currently seeing a physiotherapist or occupational therapist? Or, have you seen a therapist in the past for your mobility device? ☐ Yes ☐ No		Therapist's Name:	
		Agency:	Telephone:

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Transportation to clinic? ☐ Personal Vehicle ☐ Access Bus	
Power of Attorney (POA) for Personal Care (if applicable) or Substitute Decision Maker (SDM)	Name & Relationship:
	Telephone:
Vendor Choice:	
Funding Sources: ☐ Insurance ☐ ODSP ☐ WSIB ☐ Other:	
Please Note: If you require assistance for providing basic needs while attending clinic, a caregiver must accompany you.	
Date: YYYY/MM/DD	Referring Physician (please print):
Time: HH:MM	Referring Physician (signature):