

**MANITOBA POSSIBLE WHEELCHAIR SERVICES**

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**(SMD-010) WHEELCHAIR AND SEATING ASSESSMENT**

<b>CLIENT INFORMATION</b>	
First Name	Last Name
Grooming	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
Bowel / Bladder Management	<input type="checkbox"/> Continent <input type="checkbox"/> Bladder <input type="checkbox"/> Bowel <input type="checkbox"/> Incontinent <input type="checkbox"/> Bladder <input type="checkbox"/> Bowel
Bathing	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
Dressing	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
Eating	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
Meal Preparation	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent
Communication	<input type="checkbox"/> Verbal <input type="checkbox"/> Non Verbal <input type="checkbox"/> Augmentative Communication device <input type="checkbox"/> Able to direct care <input type="checkbox"/> Unable to direct care
Transfers	Bed -- chair <input type="checkbox"/> Independent <input type="checkbox"/> supervised <input type="checkbox"/> assisted <input type="checkbox"/> unable <input type="checkbox"/> NA Chair--commode/toilet <input type="checkbox"/> Independent <input type="checkbox"/> supervised <input type="checkbox"/> assisted <input type="checkbox"/> unable <input type="checkbox"/> NA Chair – car <input type="checkbox"/> Independent <input type="checkbox"/> supervised <input type="checkbox"/> assisted <input type="checkbox"/> unable <input type="checkbox"/> NA
Lifts	Is sling left under the client? _____
Walking	Unable to walk <input type="checkbox"/> Able to walk <input type="checkbox"/> independently <input type="checkbox"/> w/ standby supervision <input type="checkbox"/> w/ assist <input type="checkbox"/> Requires walking aid <input type="checkbox"/> yes <input type="checkbox"/> no Distance indoors _____ Distance outdoors _____
Wheelchair propulsion	Dependent indoors <input type="checkbox"/> outdoors <input type="checkbox"/> Assisted indoors <input type="checkbox"/> outdoors <input type="checkbox"/> Independent indoors <input type="checkbox"/> outdoors <input type="checkbox"/> distance indoors _____ distance outdoors _____ Method of propulsion right arm <input type="checkbox"/> left arm <input type="checkbox"/> right foot <input type="checkbox"/> left foot <input type="checkbox"/>
Home management	<input type="checkbox"/> laundry <input type="checkbox"/> cooking <input type="checkbox"/> dishwashing <input type="checkbox"/> cleaning <input type="checkbox"/> _____
Risk for falls	
Sitting Tolerance	Number of hours/ day client needs the wch _____ What limits sitting time? _____ Does client have rest periods during the day? Yes <input type="checkbox"/> No <input type="checkbox"/>
Repositioning & Pressure management	Can client reposition independently? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, how often is repositioning done? _____ Does client receive assistance with repositioning? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, from whom?

Home environment	Entrance <input type="checkbox"/> level <input type="checkbox"/> ramp with safe railing <input type="checkbox"/> lift Doorway widths in inches entrance _____ hallway _____ bedroom _____ bathroom _____ kitchen _____ elevator _____ Tight turns _____ Flooring <input type="checkbox"/> carpet <input type="checkbox"/> linoleum / hardwood <input type="checkbox"/> _____
Transportation	Personal <input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Truck <input type="checkbox"/> _____ If using own transportation client will be the <input type="checkbox"/> driver <input type="checkbox"/> passenger If driving client will <input type="checkbox"/> drive in wheelchair <input type="checkbox"/> transfer to seat Minimum van clearance height: _____ Who will load the chair? _____  Public <input type="checkbox"/> Taxi <input type="checkbox"/> Bus Transit <input type="checkbox"/> Handi Transit <input type="checkbox"/> other _____
Community	Comment on wheelchair / seating /mobility requirements to perform the following. If client already has a wheelchair, is it affecting client's ability to participate in these activities?  School Work Leisure
<b>COGNITIVE AND PERCEPTUAL FUNCTION</b>	
Cognition	Identify areas of deficit that may impact wheelchair use
Perception	Identify areas of deficit that may impact wheelchair use
<b>PHYSICAL ASSESSMENT</b>	
Strength	Comment on client's general functional strength in Right upper extremity Left upper extremity Right lower extremity Left lower extremity
Coordination	
Pain	<input type="checkbox"/> No pain <input type="checkbox"/> Pain Location Pain scale (mild) 1 2 3 4 5 6 7 8 9 10 (severe) What triggers pain? Relieved by
Tone	<input type="checkbox"/> Normal <input type="checkbox"/> Hypotonic <input type="checkbox"/> Hypertonic Triggered by Inhibited by Effect of tone on posture



<p>Current skin condition <i>Have client on plynth or bed and check all weight bearing parts.</i></p>	<input type="checkbox"/> Skin is Intact – Do skin blanching test  <input type="checkbox"/> Pressure Sore      Location of pressure sore _____ Stage _____ When did it start _____ Possible cause <input type="checkbox"/> pressure <input type="checkbox"/> shear <input type="checkbox"/> moisture What is client doing to help with the healing _____  <input type="checkbox"/> Edema      Location of edema _____ Intervention _____			
<p>Pelvis</p>	<p>Tilt</p>	<input type="checkbox"/> Neutral	<input type="checkbox"/> Pelvis in posterior tilt Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>	<input type="checkbox"/> Pelvis in anterior tilt Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>
	<p>Obliquity</p>	<input type="checkbox"/> Neutral	<input type="checkbox"/> Client's right side lower Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>	<input type="checkbox"/> Client's left side lower Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>
	<p>Rotation</p>	<input type="checkbox"/> Neutral	<input type="checkbox"/> Client's right side forward Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>	<input type="checkbox"/> Client's left side forward Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>
<p>Trunk</p>	<input type="checkbox"/> Neutral <input type="checkbox"/> Kyphosis      Thoracic <input type="checkbox"/> C-curve <input type="checkbox"/> Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/> <input type="checkbox"/> Scoliosis      convex right <input type="checkbox"/> convex left <input type="checkbox"/> Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/> <input type="checkbox"/> Rotation      Right forward <input type="checkbox"/> Left forward <input type="checkbox"/> Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>			
<p>Upper extremities</p>	Shoulders      Level <input type="checkbox"/> Asymmetrical <input type="checkbox"/> Upper extremity position			
<p>Head and neck</p>	Describe resting posture. If not neutral, Indicate if flexible toward correction.			
<p>Hip Abduction/ Adduction</p>	<input type="checkbox"/> Neutral	<input type="checkbox"/> Abducted      Right <input type="checkbox"/> Left <input type="checkbox"/> Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>	<input type="checkbox"/> Adducted      Right <input type="checkbox"/> Left <input type="checkbox"/> Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>	
	NOTE: <i>End range of hip abduction is when pelvis rotates toward that hip.</i> <i>End range of hip adduction is when pelvis rotates toward the opposite hip.</i>			
<p>Hip Internal / External Rotation</p>	<input type="checkbox"/> Neutral	<input type="checkbox"/> Externally Rotated      Right <input type="checkbox"/> Left <input type="checkbox"/> Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>	<input type="checkbox"/> Internally Rotated      Right <input type="checkbox"/> Left <input type="checkbox"/> Flexible towards correction Yes <input type="checkbox"/> No <input type="checkbox"/> Full correction <input type="checkbox"/> Partial correction <input type="checkbox"/>	
	NOTE: <i>End range of hip internal rotation is when pelvis elevates on that side.</i> <i>End range of hip external rotation is when pelvis elevates on the opposite side.</i>			

Lower Extremities		Right	Left	Comment on tone, etc
	Hip flexion ROM for seating			
	TRUNK TO THIGH ANGLE			
	THIGH TO LOWER LEG ANGLE			
	LOWER LEG TO FOOT ANGLE			

## SITTING EVALUATION

*Sit the client up over the edge of the mat. Repeat assessment of all movements while client was in supine. Determine the location and amount of effort it takes to hold the body parts in proper alignment. If possible, take picture documentation of assessment findings.*

Sitting Balance	<input type="checkbox"/> Hands free sitter & can shift weight out of midline <input type="checkbox"/> Hands free only – unable to weight shift <input type="checkbox"/> Hands dependent sitter - uses own hands on surface to stay upright <input type="checkbox"/> Dependent – requires assist to maintain upright sitting position Assistance required    minimum <input type="checkbox"/> moderate <input type="checkbox"/> maximum <input type="checkbox"/>	Describe unsupported sitting position

Pelvis	Tilt	Neutral <input type="checkbox"/> Anterior tilt <input type="checkbox"/> Posterior tilt <input type="checkbox"/> <ul style="list-style-type: none"> <li>If pelvis tends to assume a posterior tilt and client cannot independently move it to neutral, with your hands behind the pelvis, have the client lean forward and then back into upright sitting position.  Do you feel the pelvis moving back?    Yes <input type="checkbox"/>    No <input type="checkbox"/></li> <li>How much force are you providing to hold the pelvis in neutral position? Minimal <input type="checkbox"/>    Moderate <input type="checkbox"/>    Maximum <input type="checkbox"/></li> <li>If pelvis tends to assume an anterior tilt, passively move pelvis to neutral.</li> <li>If pelvis was found fixed in anterior or posterior tilt, the seating system cannot correct it to neutral but it must be supported to prevent it from progressing towards destructive posture.</li> </ul>
	Obliquity	Neutral / level <input type="checkbox"/> Clients right side low <input type="checkbox"/> Client's left side low <input type="checkbox"/> <ul style="list-style-type: none"> <li>Ask the client to level pelvis if able or passively level the pelvis. Did you achieve a level pelvis?    Yes <input type="checkbox"/>    No <input type="checkbox"/></li> <li>If unable to achieve a level pelvis and pelvic obliquity was flexible in supine, add build up on the lower side. Check pelvis again and note the outcome of this intervention.    Achieved a level pelvis <input type="checkbox"/>    Partial correction only <input type="checkbox"/></li> <li>Observe and note how this affects trunk position.</li> <li>If found fixed in supine, add build up on the higher side. Observe how this affects trunk position.</li> </ul>
	Rotation	Neutral <input type="checkbox"/> Right side forward <input type="checkbox"/> Left side forward <input type="checkbox"/> <ul style="list-style-type: none"> <li>Either have client independently correct to neutral or physically move client's pelvis to neutral.</li> <li>Did you achieve neutral pelvis?    Yes <input type="checkbox"/>    No <input type="checkbox"/></li> </ul>

Trunk	<input type="checkbox"/> Neutral <input type="checkbox"/> Kyphosis <input type="checkbox"/> Scoliosis Convex right <input type="checkbox"/> Convex left <input type="checkbox"/> <input type="checkbox"/> Rotation Forward right <input type="checkbox"/> Forward left <input type="checkbox"/>  <b>If trunk was found flexible in supine</b> , correct the client's posture so that spine is in neutral alignment or as close to neutral as possible.  Where are your hands providing support to correct or stabilize the trunk. _____ How much force is required to support, correct or stabilize the trunk? Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Maximum <input type="checkbox"/>  <b>If trunk is found fixed in supine</b> , determine best trunk position to accommodate for optimal function, balance, comfort, eye gaze, etc.  Describe where the supports are needed _____ How much force is required to accommodate the trunk position? Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Maximum <input type="checkbox"/>
Lower extremities	<ul style="list-style-type: none"> <li>▪ Position hips, knees, feet and ankle according to recorded trunk angles in supine.</li> <li>▪ Position knees according to recorded thigh to leg angle determined in supine.</li> <li>▪ Position feet/ankles according recorded leg to foot angle determined in supine.</li> </ul> Describe outcome in relation to sitting position _____ _____
Upper extremities	Shoulders are   Level <input type="checkbox"/> Asymmetrical <input type="checkbox"/> Upper extremity function _____
Head	<input type="checkbox"/> Neutral <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Laterally flexed   right <input type="checkbox"/> left <input type="checkbox"/> <input type="checkbox"/> Rotated           right <input type="checkbox"/> left <input type="checkbox"/> <input type="checkbox"/> Chin poke  <b>Head control</b> Independent <input type="checkbox"/> full ROM <input type="checkbox"/> Restricted ROM <input type="checkbox"/> Absent head control <input type="checkbox"/> Describe location of support _____ How much force is required to hold the head in position? Minimal <input type="checkbox"/> Moderate <input type="checkbox"/> Maximum <input type="checkbox"/>

<b>MEASUREMENTS</b>				
		Actual measurements		Additional Notes
1	Hip Width			
2	Chest width			
3	Trunk depth			
4	Widest width if wider than hip width (specify) _____			
5	Thigh length	R	L	
6	Lower leg length	R	L	
7	Foot length	R	L	
8	PSIS height	R	L	
9	Seat surface to hanging elbow	R	L	
10	Seat surface to inferior angle of scapula	R	L	
12	Seat surface to shoulders	R	L	
13	Seat surface to occiput			
<b>CURRENT WHEELCHAIR AND SEATING SYSTEM (include set up)</b>				
Wheelchair base				
Seating				
<b>SUMMARY AND RECOMMENDATIONS</b>				
<b>Therapist</b>		<b>Date of Assessment</b>		