INSTRUCTIONS ON COMPLETING THE APPLICATION FOR A SPECIALIZED SEATING DEVICE (2022)

SaskAbilities

ELIGIBILITY CRITERIA

The following guidelines are intended to assist therapists with applications. Although clients should meet the following criteria, it is not absolute. Each client will be considered individually.

- The client is wheelchair-dependent and their average daily use is at least 4 hours (adults) or 1-2 hours (children).
- They meet one of the following two categories:
  - They have poor trunk and/or head control and require support from the chair, OR
  - The client requires pressure relief that cannot be addressed with cushioning
- The following factors will also be considered:
  - The client cannot consistently perform independent transfers.
  - Caregiver/applicant safety may be an issue.
  - The client demonstrates altered muscle tone that impairs trunk balance.
  - There are orthopaedic considerations that interfere with upright seating.
  - There are transportation, community accessibility, pain or fatigue issues that are addressed through the use of a tilt-in-space system.

Eligible tilt-in-space models and descriptions are listed in the Special Needs Equipment Manual **at saskabilities.ca**.

BEFORE YOU SUBMIT THE APPLICATION, HAVE YOU?

- ❑ Used the most recent version of the Application for a Specialized Seating Device 2022 – available on the SaskAbilities website at **www.saskabilities.ca**
- ❑ Completed the form legibly and in its entirety. Incomplete applications will not be considered by the committee and will result in delays for approval.
- ❑ Included the required photographs.
- ❑ Included the Specialized Seating Device Set-Up Form 2022.

SUBMITTING THE APPLICATION:

By Mail:

Chairperson – Selection Committee for Specialized Seating
SaskAbilities 2310 Louise Avenue, Saskatoon, SK S7J 2C7
"CONFIDENTIAL"

By Secure Upload:

www.saskabilities.ca - Specialized Seating page (found under the Independent Living, Orthopaedics section)

Questions regarding the application form and process can be directed to SaskAbilities Specialized Seating Department at 306-385-7215 or by email at seating@saskabilities.ca.

Confidentiality Statement:
This documentation is collected to determine eligibility and the specialized seating device most appropriate to accommodate this applicant's unique needs. Completed forms will be shared with the members of the Selection Committee for Specialized Seating and will then become part of the patient file, subject to all policies and procedure related to proper storage and disposal of client information as established by SaskAbilities.

APPLICATION FOR A SPECIALIZED SEATING DEVICE (2022)

Date of Assessment:(mm/dd/yyyy)
_____

A. APPLICANT CONTACT INFORMATION		
Applicant's Name:		
HSN: *(no spaces)*	**Date of Birth:** (mm/dd/yyyy)	**Age:**
Applicant's Mailing Address:		
City/Town:	**Province:** SK	**Postal Code:**
Phone:		

B. CAREGIVER/NEXT OF KIN CONTACT INFORMATION		
Applicant Lives at: ◯ **Home** ◯ **Facility (specify) _____**		
Caregiver Name:	**Caregiver Phone:**	
Address:	**Email:**	
City/Town:	**Province:** SK	**Postal Code:**
Next of Kin and Relationship to Applicant:		

C. MEDICAL INFORMATION	
Primary diagnosis AND any other medical information pertinent to wheelchair prescription and seating:	
Physician Name:	**Phone:**
Date physician informed of seating recommendation AND any comments from physician:	

Is the applicant's medical condition designated as palliative? ◯ **YES** **or** ◯ **NO**
If yes, please include supporting documentation (letter from physician or other supporting document).

Is the wheelchair required for discharge? ◯ **YES** **or** ◯ **NO**
If yes, what is the anticipated date of discharge?

D. CURRENT SEATING CONCERNS (to be completed in consult with client and caregiver):

1.

2.

3.

E. PRESENT FUNCTIONAL STATUS:

Vision:
- ◯ Normal
- ◯ Impaired

Hearing:
- ◯ Normal
- ◯ Impaired

Communication:
- ◯ Normal
- ◯ Impaired

Swallowing Reflexes:
- ◯ Normal
- ◯ Abnormal

Eating:
- ◯ Independent
- ◯ Partial Assist
- ◯ Dependent
- ◯ Feeding Tube

Toileting:
- ◯ Self
- ◯ Continent
- ◯ Incontinent
- ◯ Catheter
- ◯ Bedpan/urinal

Standing Balance:
- ◯ Normal
- ◯ Minimal Assist
- ◯ Moderate Assist
- ◯ Unable

Transfers:
- ◯ Independent
- ◯ Min/Mod Assist
- ◯ Sliding Board
- ◯ Sit/stand Lift
- ◯ Total Lift

Ambulation:
- ☐ Independent
- ☐ Short Distance
- ☐ With Device
- ☐ With Assistance
- ☐ Unable

Functional Trunk Control in Sitting:
- ◯ Full
- ◯ Partial
- ◯ None

Trunk falls:
- ☐ Forward
- ☐ Left
- ☐ Right
- ☐ Backwards
- ☐ N/A

Functional Head and Neck Control when alert:
- ◯ Full
- ◯ Partial
- ◯ None

Head falls:
- ☐ Forward
- ☐ Left
- ☐ Right
- ☐ Backwards
- ☐ N/A

Comments:

F. SKIN HEALTH

Sensation:
- ◯ Intact
- ◯ Impaired
- ◯ Absent

PURS Score: _____
OR
Braden Score: _____

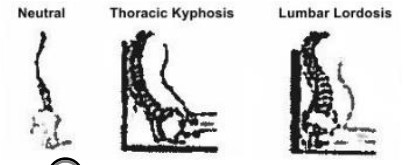
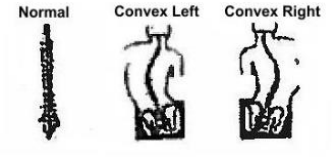
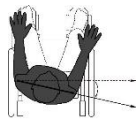
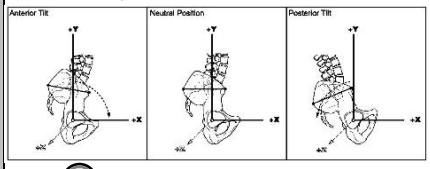
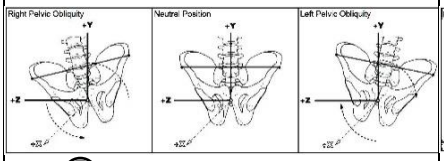
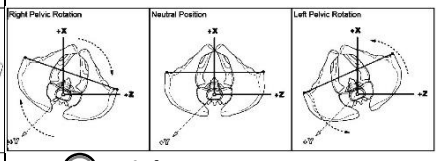
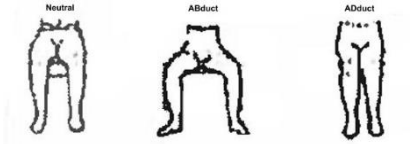
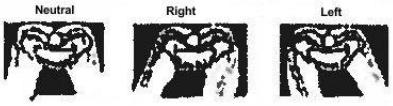
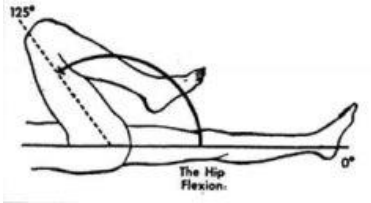
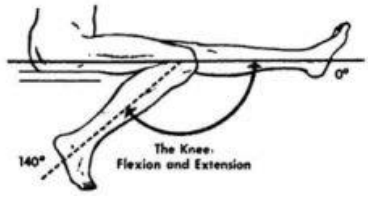
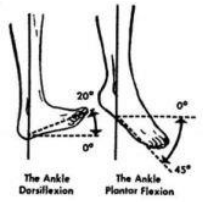
History of Pressure Sores:
- ◯ Yes
- ◯ No

Current Pressure Sores:
- ◯ Yes
- ◯ No

Location of current pressure sores AND other comments related to skin health:

G. CURRENT SEATING STATUS:			
Current Wheelchair Type: ◯ None ◯ Model: _____	**Current Wheelchair Size:** Width: _____ inches Depth: _____ inches	**Method of Propulsion:** ◯ Independent ◯ Dependent ◯ Motorized	**For Independent Propulsion only:** ◯ Hand ◯ Foot ◯ Combination
Current Seating Status: Client is seated _____ hours/day Repositioned _____ times/day	**Independent Weight Shifts** ◯ Yes ◯ No	**Wheelchair Transported By:** ◯ Car ◯ Accessible transportation	
History of seating interventions tried to date (backrests, cushions, wheelchair set-up, etc.):			

H. CURRENT PHYSICAL STATUS:			
Tone	**Tone – Describe tonal abnormalities which impact seating**	**Reflexes – Describe reflexes or involuntary movements which impact seating**	**Additional Comments**
Head and Neck	**Cervical Kyphosis:** ◯ Yes ◯ No ◯ Reducible ◯ Non-reducible **Capital Extension:** ◯ Yes ◯ No ◯ Reducible ◯ Non-reducible	**Upper Extremity** **Shoulders** ◯ Normal ◯ Asymmetrical ◯ Protracted ◯ Retracted	**Additional Comments**

Trunk	**Anterior/Posterior**  ◯ Normal ◯ Thoracic kyphosis ◯ Lumbar lordosis ◯ Reducible ◯ Non-reducible	**Left/Right**  ◯ Normal ◯ Convex left ◯ Convex right ◯ Reducible ◯ Non-reducible	**Rotation**  ◯ Neutral ◯ Left ◯ Right ◯ Reducible ◯ Non-reducible
Pelvis	**Anterior/Posterior Tilt**  ◯ Anterior ◯ Neutral ◯ Posterior ◯ Reducible ◯ Non-reducible	**Obliquity**  ◯ Right high ◯ Neutral ◯ Left high ◯ Reducible ◯ Non-reducible	**Rotation**  ◯ Right ◯ Neutral ◯ Left ◯ Reducible ◯ Non-reducible
Hips	**Position**  ◯ Neutral ◯ Abduct ◯ Adduct ◯ Reducible ◯ Non-reducible	**Windswept**  ◯ Neutral ◯ Right ◯ Left ◯ Reducible ◯ Non-reducible	**Hip Range of Motion**  **L Range: _____ º to _____ º** **R Range: _____ º to _____ º** **(Typical values: 0 – 120º)**
Knees and Feet	**Knee Range of Motion**  **L Range: _____ º to _____ º** **R Range: _____ º to _____ º** **(Typical values: 0 – 120º)**	**Foot Range of Motion**  **L Range: _____ º to _____ º** **R Range: _____ º to _____ º** **(Typical values: 0 – 45º)**	**Foot Positioning** • **Normal** ◯L ◯R • **Dorsi-flexed** ◯L ◯R • **Plantar flexed** ◯L ◯R • **Inversion** ◯L ◯R • **Eversion** ◯L ◯R

I. PHOTOGRAPHS (REQUIRED TO SUPPORT THE APPLICATION):

Please submit at least 4 photographs which show anterior, posterior, and lateral views of applicant in their current seating system. If recommended system was trialed, please provide additional photos showing the same views with applicant upright, and with the applicant in tilted position.
If these photos do not demonstrate current seating problems or intended benefits of the system, please explain.

J. ADDITIONAL COMMENTS:

Is there any additional information you would like to provide to the Selection Committee which has not been covered on other sections of this form? If eligibility criteria are not clearly met, please explain here.

K. THERAPIST SUMMARY:

Goals for Seating:

Recommended Seating System:
Available tilt-in-space models are listed in Special Needs Equipment Manual. Please note that the AMS iTilt model is the standard issue. If requesting an alterative model, please explain.

Has the applicant trialled recommended seating system? ◯ **YES** **or** ◯ **NO**
If yes, please comment on the outcomes of the trial.

Does the applicant tolerate a tilted seating position? ◯ **YES** **or** ◯ **NO**

L. APPLICATION COMPLETED BY:		
Therapist Name:	**Designation:**	
Therapist Address:		
City/Town:	**Province:** SK	**Postal Code:**
Phone:	**Email:**	
Signature:	**Date:** (mm/dd/yyyy)	
M. PERSON DESIGNATED FOR FOLLOW-UP:		
Name:	**Designation:**	
Address:		
City/Town:	**Province:** SK	**Postal Code:**
Phone:	**Email:**	

FOR SPECIALIZED SEATING COMMITTEE USE ONLY
Date Application Reviewed:
Recommendations:
Date Application Approved:

SPECIALIZED SEATING DEVICE SET-UP FORM (2022)

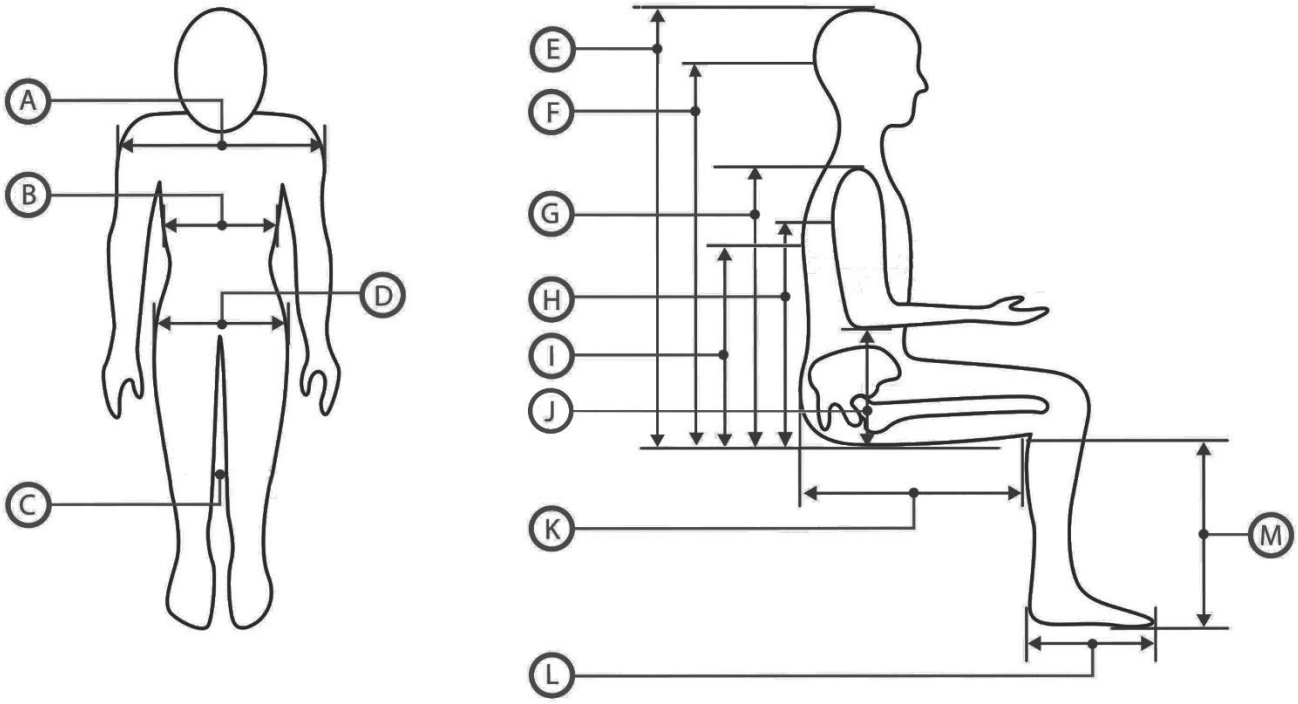
A. CLIENT MEASUREMENTS:

Measurements are recorded in:

- ◯ **Inches**
- ◯ **Centimetres**

***Note: Measurements should be taken with applicant wearing indoor clothing.**

Standing Height:	**Weight:** ◯ **Pounds or** ◯ **Kilograms**



REFER TO DIAGRAM ABOVE TO MEASURE		**Left Side**	**Right Side**
A. Shoulder width:	**G. Seat to top of shoulder:**		
B. Chest width:	**H. Seat to axilla:**		
C. Between knees:	**I. Seat to scapula:**		
D. Hip width:	**J. Seat to elbow:**		
E. Seat to top of head:	**K. Sitting surface from behind knees:**		
F. Seat to occiput:	**L. Foot length:**		
	M. Lower leg length:		

B. SEATING DEVICE SPECIFICATIONS:

Seat Width:

Seat Depth:

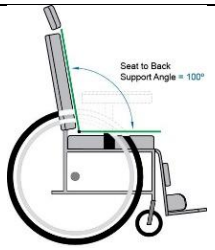
Standard configurations for an AMS iTilt 2 are:

- ✓ **Flat seat base**
- ✓ **Seat base to back cane angle – 100 °**
- ✓ **24" rear wheels and 8" front casters**
- ✓ **Floor to seat base – 19" (not including cushion)**
- ✓ **Angle adjustable footplates**
- ✓ **Standard padded AMS headrest with fixed headrest hardware mounted on backrest**
- ✓ **Standard positioning belt (non-padded)**
- ✓ **Padded leg rest panel**
- ✓ **NXT Xtend Deep Back (height adjustable)**

Wheelchair specifications being requested that differ from the standard (listed above):

Seat to Floor Height:

Seat to Back Angle:



Footrest Hangers:

- ◯ **70 °**
- ◯ **90 ° (difficult on AMS wheelchairs)**
- ◯ **Manual elevating**

C. ADDITIONAL ADAPTIVE SEATING COMPONENTS:

Tray:

- ◯ **Full Padded**
- ◯ **Full Padded with back strap**
- ◯ **Full Tray (½ Clear, ½ Padded)**
- ◯ **Other: _____**

Cushion:

- ◯ **Existing cushion adequate**
- ◯ **Cushion previously requested through Special Needs Equipment**
- ◯ **New cushion request enclosed (please include a Special Needs Equipment Requisition Form)**
- ◯ **Custom cushion required (please include a Custom Wheelchair Seat Form)**

Cushion Details:

- ✓ **Type: _____**
- ✓ **Size: _____**

Wheelchair adaptations not covered above (please call Specialized Seating to discuss options):

D. SEATING SYSTEM FITTING/DELIVERY

When the seating system has been set-up for the client, the seating team should:

- ◯ **Contact client/caregiver for pickup**
- ◯ **Contact follow-up designate (listed on application) for fitting appointment**
- ◯ **Send to facility for fitting**
- ◯ **Other, please specify: _____**

? Questions regarding the set-up form should be directed to SaskAbilities Specialized Seating Department
Phone: **306-385-7215** Email **seating@saskabilities.ca**