

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



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.



PLEASE MAIL COMPLETED FORM AND SUPPORTING DOCUMENTATION TO:

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



BEFORE YOU SEND IN 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](#).



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)

A. APPLICANT CONTACT INFORMATION		
Applicant's Name:		
HSN:	Date of Birth:	Age:
Applicant's Mailing Address:		
City/Town:	Province: SK	Postal Code:
Phone: ()		
B. CAREGIVER/NEXT OF KIN CONTACT INFORMATION		
Applicant Lives at: <input type="checkbox"/> Home <input type="checkbox"/> Facility (specify) _____		
Caregiver Name:	Caregiver Phone: ()	
Address:	Email:	
City/Town:	Province:	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? <input type="checkbox"/> YES or <input type="checkbox"/> NO If yes, please include supporting documentation (letter from physician or other supporting document).		
Is the wheelchair required for discharge? <input type="checkbox"/> YES or <input type="checkbox"/> 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: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired	Hearing: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired	Communication: <input type="checkbox"/> Normal <input type="checkbox"/> Impaired	
Swallowing Reflexes: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Eating: <input type="checkbox"/> Independent <input type="checkbox"/> Partial Assist <input type="checkbox"/> Dependent <input type="checkbox"/> Feeding Tube	Toileting: <input type="checkbox"/> Self <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter <input type="checkbox"/> Bedpan/urinal	
Standing Balance: <input type="checkbox"/> Normal <input type="checkbox"/> Minimal Assist <input type="checkbox"/> Moderate Assist <input type="checkbox"/> Unable	Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Min/Mod Assist <input type="checkbox"/> Sliding Board <input type="checkbox"/> Sit/stand lift <input type="checkbox"/> Total Lift	Ambulation: <input type="checkbox"/> Independent <input type="checkbox"/> Short Distance <input type="checkbox"/> With Device <input type="checkbox"/> With Assistance <input type="checkbox"/> Unable	
Functional Trunk Control in Sitting: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None	Trunk falls: <input type="checkbox"/> Forward <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Backwards <input type="checkbox"/> N/A	Functional Head and Neck Control when alert: <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> None	
		Head falls: <input type="checkbox"/> Forward <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Backwards <input type="checkbox"/> N/A	

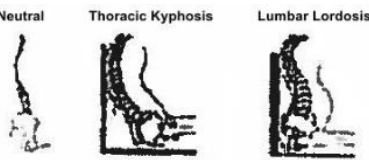
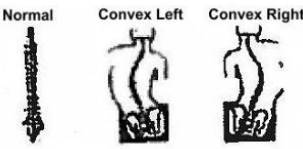
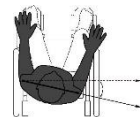
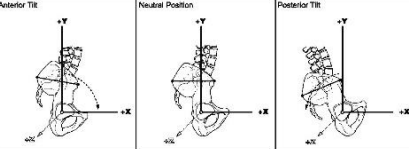
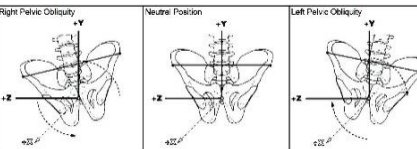
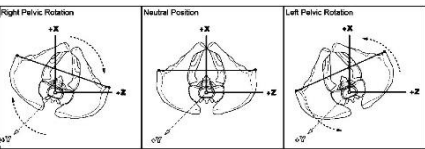
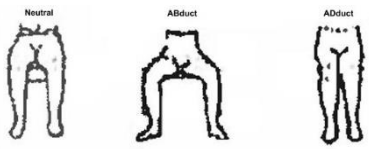
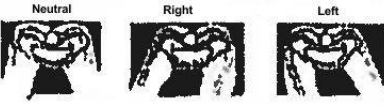
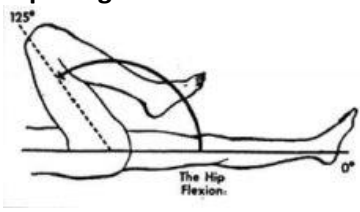
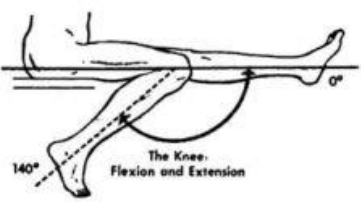
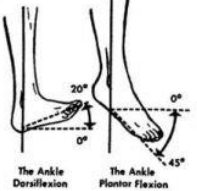
Comments:

F. SKIN HEALTH

Sensation: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent	PURS Score: _____ OR Braden Score: _____	History of Pressure Sores: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Pressure Sores: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Location of current pressure sores AND other comments related to skin health:

G. CURRENT SEATING STATUS:			
Current Wheelchair Type: <input type="checkbox"/> None <input type="checkbox"/> Model: _____	Current Wheelchair Size: Width: _____ inches Depth: _____ inches	Method of Propulsion: <input type="checkbox"/> Independent <input type="checkbox"/> Dependent <input type="checkbox"/> Motorized	For Independent Propulsion only: <input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Combination
Current Seating Status: Client is seated _____ hours/day Repositioned _____ times/day	Independent Weight Shifts <input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair Transported By: <input type="checkbox"/> Car <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible Capital Extension: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible	Upper Extremity Shoulders <input type="checkbox"/> Normal <input type="checkbox"/> Asymmetrical <input type="checkbox"/> Protracted <input type="checkbox"/> Retracted	Additional Comments

Trunk	<p>Anterior/Posterior</p> <p>Neutral Thoracic Kyphosis Lumbar Lordosis</p>  <p> <input type="checkbox"/> Normal <input type="checkbox"/> Thoracic kyphosis <input type="checkbox"/> Lumbar lordosis </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>	<p>Left/Right</p> <p>Normal Convex Left Convex Right</p>  <p> <input type="checkbox"/> Normal <input type="checkbox"/> Convex left <input type="checkbox"/> Convex right </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>	<p>Rotation</p>  <p> <input type="checkbox"/> Neutral <input type="checkbox"/> Left <input type="checkbox"/> Right </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>
Pelvis	<p>Anterior/Posterior Tilt</p> <p>Anterior Tilt Neutral Position Posterior Tilt</p>  <p> <input type="checkbox"/> Anterior <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>	<p>Obliquity</p> <p>Right Pelvic Obliquity Neutral Position Left Pelvic Obliquity</p>  <p> <input type="checkbox"/> Right high <input type="checkbox"/> Neutral <input type="checkbox"/> Left high </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>	<p>Rotation</p> <p>Right Pelvic Rotation Neutral Position Left Pelvic Rotation</p>  <p> <input type="checkbox"/> Right <input type="checkbox"/> Neutral <input type="checkbox"/> Left </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>
Hips	<p>Position</p> <p>Neutral Abduct Adduct</p>  <p> <input type="checkbox"/> Neutral <input type="checkbox"/> Abduct <input type="checkbox"/> Adduct </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>	<p>Windswept</p> <p>Neutral Right Left</p>  <p> <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left </p> <p> <input type="checkbox"/> Reducible <input type="checkbox"/> Non-reducible </p>	<p>Hip Range of Motion</p>  <p>L Range: _____ ° to _____ ° R Range: _____ ° to _____ ° (Typical values: 0 – 120°)</p>
Knees and Feet	<p>Knee Range of Motion</p>  <p>L Range: _____ ° to _____ ° R Range: _____ ° to _____ ° (Typical values: 0 – 120°)</p>	<p>Foot Range of Motion</p>  <p>L Range: _____ ° to _____ ° R Range: _____ ° to _____ ° (Typical values: 0 – 45°)</p>	<p>Foot Positioning</p> <ul style="list-style-type: none"> • Normal <input type="checkbox"/> L <input type="checkbox"/> R • Dorsi-flexed <input type="checkbox"/> L <input type="checkbox"/> R • Plantar flexed <input type="checkbox"/> L <input type="checkbox"/> R • Inversion <input type="checkbox"/> L <input type="checkbox"/> R • Eversion <input type="checkbox"/> L <input type="checkbox"/> 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 alternative model, please explain.

Has the applicant trialed 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:	Postal Code:
Phone: ()		Email:	
Signature:		Date:	

M. PERSON DESIGNATED FOR FOLLOW-UP:

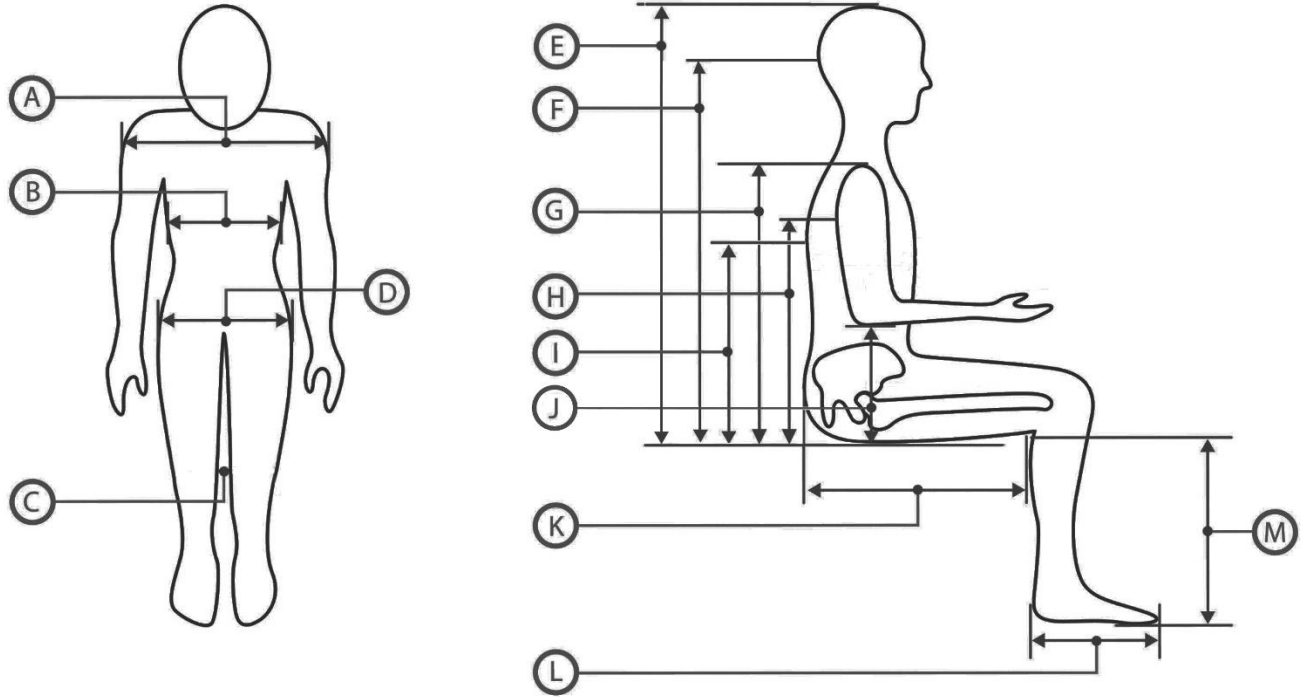
Name:		Designation:	
Address:			
City/Town:		Province:	Postal Code:
Phone: ()		Email:	

FOR SPECIALIZED SEATING COMMITTEE USE ONLY

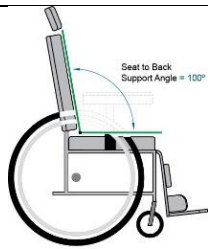
Date Application Reviewed:
Recommendations:
Date Application Approved:

SPECIALIZED SEATING DEVICE SET-UP FORM (2022)

A. CLIENT MEASUREMENTS:	
Measurements are recorded in: <input type="checkbox"/> Inches <input type="checkbox"/> Centimetres	*Note: Measurements should be taken with applicant wearing indoor clothing.
Standing Height:	Weight: <input type="checkbox"/> Pounds or <input type="checkbox"/> 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: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> <input type="checkbox"/> 70 ° <input type="checkbox"/> 90 ° (difficult on AMS wheelchairs) <input type="checkbox"/> Manual elevating
C. ADDITIONAL ADAPTIVE SEATING COMPONENTS:	
Tray: <ul style="list-style-type: none"> <input type="checkbox"/> Full Padded <input type="checkbox"/> Full Padded with back strap <input type="checkbox"/> Full Tray (½ Clear, ½ Padded) <input type="checkbox"/> Other: _____ 	
Cushion: <ul style="list-style-type: none"> <input type="checkbox"/> Existing cushion adequate <input type="checkbox"/> Cushion previously requested through Special Needs Equipment <input type="checkbox"/> New cushion request enclosed (please include a <u>Special Needs Equipment Requisition Form</u>) <input type="checkbox"/> Custom cushion required (please include a <u>Custom Wheelchair Seat Form</u>) 	Cushion Details: <ul style="list-style-type: none"> ✓ 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: <ul style="list-style-type: none"> <input type="checkbox"/> Contact client/caregiver for pickup <input type="checkbox"/> Contact follow-up designate (listed on application) for fitting appointment <input type="checkbox"/> Send to facility for fitting <input type="checkbox"/> 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