St. Joseph's Health Care London
Parkwood Seating Program
PO Box 5777, STN B,
London ON N6A 4V2
(519) 685-4292, ext. 42199
FAX (519) 685-4560

Office Use Only	
Appointment Date	Hospital Chart No.
Referral Source	Service Avenue

Parkwood Seating Program Pre-Assessment Form

THIS DEMOGRAPHIC SECTION MUST BE COMPLETED IN FULL

Name		
Street Address		
City		**Postal Code**
Home Telephone		**Work Telephone**
Health Card Number		**Birthdate**
Family or Referral Doctor		
Diagnosis		
Name of Contact Person		**Telephone**

Wheel chair	Do you presently have a wheelchair?	☐ Yes ☐ No
	☐ Manual Wheelchair ☐ Power Wheelchair	☐ Other
	How long have you had your current wheelchair?	

Seating Concerns	**What are your current seating concerns?**	
	☐ Pain/Comfort	☐ Mobility
	☐ Posture/Sitting Support	☐ Condition of Current Wheelchair
	☐ Pressure Area/Skin Breakdown – if box 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? (Specify)**	
	☐ New manual wheelchair	☐ New power wheelchair
	☐ New cushion	☐ Improved comfort
	☐ Improved mobility	☐ New back support
	☐ Improve pressure reduction	☐ Improved posture

Patient Name	M.R. #

Do you use an augmentative communication device? ☐ Yes ☐ No	Have you being seen at an Augmentative Communication Clinic in the past 5 years? ☐ Yes ☐ No
Have you been seen at the Thames Valley Children's Centre Seating Clinic in the past 5 years? ☐ Yes ☐ No	

Are you currently seeing a physiotherapist or occupational therapist? ☐ Yes ☐ No	Therapist's Name	
	Agency	Telephone
Transportation to clinic? ☐ Personal Vehicle ☐ Paratransit ☐ Ambulance		
Power of Attorney for Personal Care (if applicable) or Substitute Decision Maker	Name & Relationship	
	Telephone	
Power of Attorney for Finances (if applicable)	Name & Relationship	
	Telephone	
Vendor Choice		

Please Note:
If you require assistance for providing basic needs while attending clinic, a caregiver must accompany you.

Signature	**Date**

If signature is other than client, please identify relationship.	