Email Reset Form

Queensland Government

Royal Brisbane & Women's Hospital

Rehabilitation Engineering

CUSTOM SEATING REFERRAL FORM

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

REC ADMIN ONLY

Received on: .....

OSIM / Spreadsheet Triage Category: ☐ 1 ☐ 2 ☐ 3 Est. time: .....

☐ Update record ☐ Seating Clinic New ☐ Pressure Ulcer Clinic

☐ Email Therapist ☐ Seating Clinic Review ☐ Seating Clinic Complex

☐ Manufacture only

☐ No chart ☐ REC Chart Comments:

☐ Referral cancelled

By: .....

Date: ..... Triage by: ..... Date: .....

Contact Details

Date: ..... Previous REC Client? ☐ Yes ☐ No

Given Name: ..... Surname: ..... Date of Birth: .....

Address: ..... Phone: .....

Medicare number: ..... Medicare ID: ..... Expiry Date: .....

Patient Status: ☐ DVA ☐ Motor Vehicle Insurance ☐ WorkCover

Preferred Contact Person: ..... Relationship to Client: .....

Phone: ..... Email: .....

Relevant Diagnosis: .....

Referring Therapist

Name: .....

Position: .....

Organisation: .....

Address: .....

.....

Phone: .....

Mobile: .....

Email: .....

Primary Therapist *(optional)*

Name: .....

Position: .....

Organisation: .....

Address: .....

.....

Phone: .....

Mobile: .....

Email: .....

Who should REC contact regarding appointment information?

☐ Client ☐ Next of Kin/Contact ☐ Therapist - Referring ☐ Primary Therapist

CUSTOM SEATING REFERRAL FORM

MR 60082 V2.00 - 11/2013 *Locally Printed*

00201:60082

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Triage – Mobility Device

Please provide as much information as you need to give a clear picture to the REC team i.e., photos, clinical / assessment notes etc. Additional pages can be added if needed

1. What are the current seating issues?

2. What have you trialled and why was it ineffective?

3. What are the seating goals for this referral?

4. What do you think needs to be done to achieve this?

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Triage – Mobility Device cont.

5. Is the Client at risk of physical injury because of a mechanical failure (broken parts) in the seating system? ☐ Yes ☐ No

If yes, have you contacted supplied (if applicable) for repairs? ☐ Yes ☐ No

Details:

6. What is the mobility device that is to be modified (manual, power, make and model)?

7. (a) How long has the Client had this device (b) when is Client likely to receive it?

8. Was this device funded by the Medical Aids Subsidy Scheme? If so, please provide plaque number.

9. Has this device previously been modified? If yes, by whom?

Triage Data

1. Is the Client's primary diagnosis:

☐ Stable Progressive - Degenerative ☐ Stable phase / ☐ Degenerative phase

Based on the International Classification of Functioning (ICF) framework, please provide information on the following factors.

2. Body Functions and Structures

Please describe the current concerns relating to the Client's body structure (posture) and physiological function when in the mobility device.

Examples: Joint Range, Contractures, Muscle Tone, Posture, Sensation, Pressure, Pain and or Significant Recent Changes / Surgery

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3. What level of sensation does the Client have?

☐ Full sensation to all body parts
☐ Partial loss of sensation
☐ Total loss of sensation
☐ Unable to assess

Comment:

4. Activity & Participation

Please describe the current (seating) concerns relating to the Client's ability to complete activities or participate in life situations i.e. Activities of Daily Living, Communication, School, Work.

Examples: Sitting tolerance, transfers, toileting, feeding, breathing, propulsion and / or transport

5. What is the Client's level of independence in regard to positioning in their chair?

☐ Able to perform full pressure lift
☐ Self transfer in and out of chair
☐ Able to reposition self but not to perform pressure tilt
☐ Unable to reposition self
☐ Unable to communication discomfort

Comment:

6. Environmental / Other Contextual Factors

Please provide information on: Client's social / care situation, any safety concerns or behavioural issues.

Please attach photos of Client in their current seating system.

Send completed referrals to:

Email - Rehab-Eng@health.qld.gov.au Fax: 3646 1785 Phone: 3646 7773

Post: Rehabilitation Engineering, Ground Floor Coles Building, Royal Children's Hospital, Herston 4029

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