

SEATING CLINIC ASSESSMENT



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Patient name: _____

Date: _____ **Sex:** _____ **DOB:** _____

Age: _____ **Height:** _____ **Weight:** _____

Tel (home): _____ **Tel (work):** _____ **Tel (cell):** _____

Address: _____

Diagnosis: _____ **ASIA:** _____

Date of onset: _____ **Other Injuries:** _____

Relevant medical history: _____

Funder: _____

Cost bracket: _____ **Pre-authorisation: Y / N**

Referred by : _____ **In Px / Out Px**

Reason for referral : _____

Assessed by :

Physio: _____ **Speech therapist:** _____

OT: _____ **Orthotist:** _____

Social worker: _____ **Rehab co-ordinator:** _____

SOCIAL ASSESSMENT

ACCESSIBILITY

- Home
- | | | |
|--|---|--|
| <input type="checkbox"/> Accessible | <input type="checkbox"/> Narrow doorways | <input type="checkbox"/> Small turning circles |
| <input type="checkbox"/> Awaiting assessment | <input type="checkbox"/> Awaiting alterations | <input type="checkbox"/> Fully adapted |
| <input type="checkbox"/> Thresholds | <input type="checkbox"/> Small step | <input type="checkbox"/> Steps |
| <input type="checkbox"/> Ramp | How steep: | |

Comments

.....

.....

- Work
- | | | |
|--|---|--|
| <input type="checkbox"/> Accessible | <input type="checkbox"/> Narrow doorways | <input type="checkbox"/> Small turning circles |
| <input type="checkbox"/> Awaiting assessment | <input type="checkbox"/> Awaiting alterations | <input type="checkbox"/> Fully adapted |
| <input type="checkbox"/> Thresholds | <input type="checkbox"/> Small step | <input type="checkbox"/> Steps |
| <input type="checkbox"/> Desks accessible | <input type="checkbox"/> Toilets accessible | <input type="checkbox"/> Transport accessible |

- Transport
- | | | |
|--|---|---|
| <input type="checkbox"/> Taxi | <input type="checkbox"/> Train | <input type="checkbox"/> Own car |
| <input type="checkbox"/> Drive adapted vehicle | <input type="checkbox"/> Load wheelchair self | <input type="checkbox"/> Wheelchair hoist |

SPORT & RECREATION

- Wheelchair use
- | | | |
|--|--|---|
| <input type="checkbox"/> Manual self propelled | <input type="checkbox"/> Motorised | <input type="checkbox"/> Pushed around |
| <input type="checkbox"/> 0-3 hours per day | <input type="checkbox"/> 3-8 hours per day | <input type="checkbox"/> 8-14 hours per day |
| <input type="checkbox"/> For longer distances | <input type="checkbox"/> For all mobility | <input type="checkbox"/> For sport |
| <input type="checkbox"/> Indoors | <input type="checkbox"/> Outdoors | <input type="checkbox"/> Curbs |

CARER NEEDS

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Totally independent | <input type="checkbox"/> Use 1 carer | <input type="checkbox"/> Use multiple carers |
|--|--------------------------------------|--|

GENERAL

- | | | | |
|------------------------|---------------------------------------|--|--|
| Motivation | <input type="checkbox"/> Satisfactory | <input type="checkbox"/> Unsatisfactory | <input type="checkbox"/> Needs support |
| Cognitive function | <input type="checkbox"/> Normal | <input type="checkbox"/> Slightly impaired | <input type="checkbox"/> Severely impaired |
| Insight into condition | <input type="checkbox"/> Good | <input type="checkbox"/> Moderate | <input type="checkbox"/> Poor |
| Alcohol/drug use | <input type="checkbox"/> None | <input type="checkbox"/> Occasional/Social | <input type="checkbox"/> Excessive |

RISK ASSESSMENT

HISTORY

Pressure sores Never had a pressure sore Currently has a pressure sore Have had a pressure sore

IF HAD PRESSURE SORE, HOW MANY TIMES:

IF HAD PRESSURE SORE, WHERE:

WHEN DID YOU RECOVER FROM MOST RECENT PRESSURE SORE:

Surgery None for pressure sores Debridement Skin flap

WHEN:

Smoking Never Used to Yes
 STOPPED:
 HOW MANY / DAY:

Other Diabetic Anaemic Peripheral vascular disease

Waterlow Score

10+ AT RISK

15+ HIGH RISK

20+ VERY HIGH RISK

SKIN CARE

Pressure relief Independently Need assistance Don't do pressure relief

Method of pressure relief Lifting Side leaning Forward leaning

Interval Every 30 minutes Every hour 6 times a day
 3 times a day Never Move around in w/ch

Education Have no understanding of pressure sores Have attended a lecture Have a booklet

Skin inspection Don't do inspection Use a mirror Carer checks
 In the morning In the evening

Continence Have bladder accidents Have bowel accidents

GENERAL HEALTH

Poor Average Good

