

**UNIVERSAL ASSESSMENT FORM
For Seated Mobility**

BASIC

DRAFT – APRIL 2005



This is one of a pair of draft assessment forms that have been brought together as a British Healthcare Trades Association (BHTA) initiative by a team of therapists, engineers, and contributors from the commercial sector, in an attempt to combine best practice, and to service the needs of the medical and commercial sectors, while using the latest measurement standards.

This basic form covers the requirements for clients without complex needs, but has been designed to alert assessors to where a more detailed assessment, possibly by a more qualified person, is needed. There is a 'complex' form to cover these needs.

The team is seeking feedback as to the value, and shortcomings, of these forms. Please would you try this form out and let us have your feedback. Further copies of the assessment forms, and feedback forms are available on www.pmguk.co.uk

MOBILITY SEATING DOCUMENT – BASIC LEVEL

SECTION B1 - SCREENING

Prepared by _____ Date _____

Position _____

B1:1 CLIENT

Client first name(s): _____

Client last name: _____

Address: _____

Postcode: _____

GP: _____

NHS Reference number: _____

Date of birth (dd/mm/yy): _____

Sex: Male _____ Female _____

Height: _____

Weight: _____

Diagnosis: Primary: _____

Secondary: _____

Other Considerations: _____

Home phone number: _____

Daytime phone number: _____

Email address: _____

B1:2 CARER

Carer name: _____

Carer tel no: _____

Clinical contact name: _____

(OT, PT, Nurse, other _____)

Contact tel no: _____

B1:3 REFERRAL:

Referred by: _____

Reason for Referral: _____

Date for assessment: _____

By Whom: _____

Place of assessment: _____

Key Worker/Contact: _____

B1:4 CLIENT INFORMATION

B1.4.1 Client's expectations from assessment:

B1.4.2 Communication:

English Y/N Other: _____

Interpreter Available Y/N

Relationship of interpreter/client: _____

Communication Equipment Y/N Define: _____

Please consider the following relative to problems that could affect a) your assessment and b) the impact on the use of the wheelchair.

Hearing: Normal Y/N Partial Loss Y/N Total loss Y/N
 Unknown/not testable Y/N Uses aids Y/N If Y specify: _____

Vision:

Existence of a visual problem? Y/N

Define problems: _____

Cognition:

Are there any cognitive problems Y/N Define: _____

Perception:

Are there any perceptual problems Y/N Define: _____

B1.4.3 Orthotics:

Below knee caliper (AFO)

Long leg caliper

Spinal Jacket

Neck Collar

Prosthetics:

R/L Does user use an artificial limb? Y/N

R/L Define _____

Frequency of use _____

B1.4.4 Current equipment in use:

Main Wheelchair (Model/Make):	
Issued when?	By Whom
Cushion (Model/Make):	
Issued when?	By Whom
Accessories 1:	
Issued when?	By Whom
Accessories 2:	
Issued when?	By Whom

B1.4.5 Living Environment:

Alone: Y/N If no, with whom: _____

House: Y/N Bungalow Y/N Flat Y/N (lives on floor: _____)
(Lift: Y/N) (Stairs: Y/N)

Owns: Y/N Rents: Y/N

Storage availability: Y/N Where: _____

Steps from street to living area: _____

B1.4.6 Current Function:

Wheelchair User: Y/N Full time / Part time Hours per day: _____

Other seating used: _____

Dependent: Y/N Independent: Y/N Occasionally assisted: Y/N

Self-propelling method:

Arms	Left	<input type="checkbox"/>
	Right	<input type="checkbox"/>
Legs	Left	<input type="checkbox"/>
	Right	<input type="checkbox"/>

B1.4.7 Method of transfer:

Independent	Y/N	Method: _____	Level transfers:	Y/N
			Split level transfers:	Y/N
Dependent	Y/N	Method: _____	Level transfers:	Y/N
			Split level transfers:	Y/N

B1:5 EQUIPMENT PREVIOUSLY USED

To include wheelchairs, seating and accessories.

Date	Type	Outcome

B1:6 OTHER RELEVANT INFORMATION /NOTES:

EVALUATION OF PHYSICAL PRESENTATION – BASIC LEVEL

SECTION B2

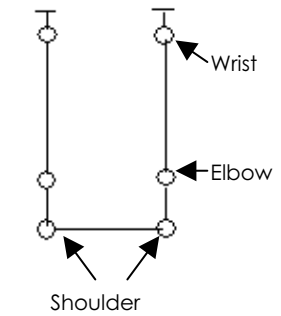
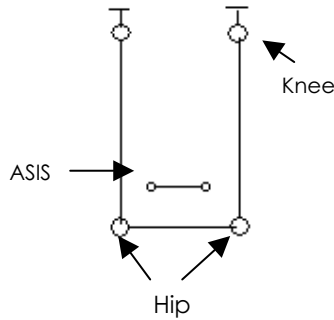
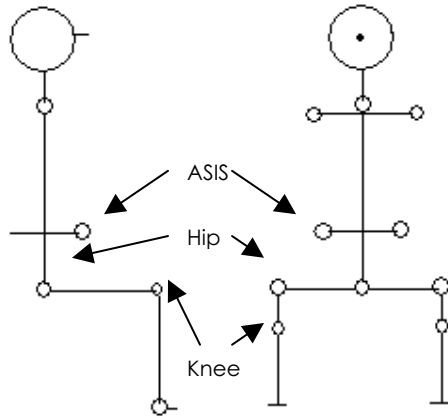
Assessment carried out on/in: _____ (e.g. stable chair, plinth)

Sagittal Plane
(sideways from right)

Frontal Plane
R L

Transverse Plane
Pelvis
L R

Transverse Plane
Upper Torso
L R



KEY SYMBOLS



Normal



Curvature



Rotation



Downwards



Upwards

Possible indications for more advanced assessment:

- Attitude of arms (e.g. flexed, extended, supporting, functional for ADL etc).
- Degree of head control (underline appropriately).
None, intermittent, sustained but for a limited period.
- Other considerations (orthosis, evidence of increased/decreased tone, sensation).
- Is a more detailed assessment necessary? Y/N
- Date of assessment: _____

Signed: _____

Notes:

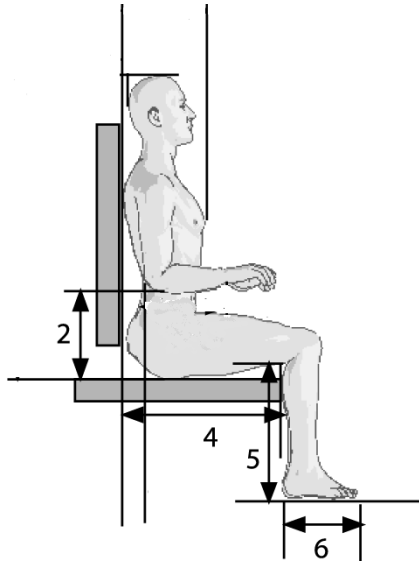
To Complete:

Overdraw in RED, using the key symbols, any deviations from the norm. If there are any significant deviations seek multi-disciplinary input from a qualified clinical professional.

LINEAR MEASUREMENTS OF THE BODY – BASIC LEVEL

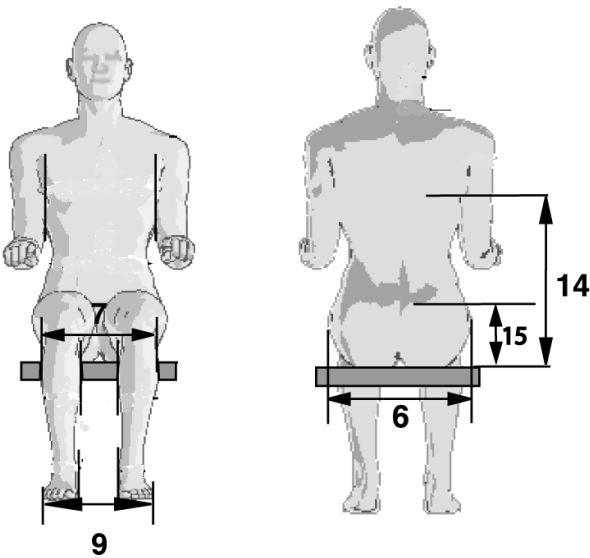
SECTION B3

B3:1 Sagittal Plane*



	Linear Body Measurement	Actual measurements (cms)	
		R	L
1	Elbow Height: 2		
2	Buttock/thigh depth: 4		
3	Lower leg length: 5		
4	Foot depth: 6		

B3:2 Frontal Plane*



	Linear Body Measurement	Actual measurements (cms)
1	Pelvic width: 6	
2	Scapula height: 14	
3	PSIS height: 15	
4	External knee width: 7	
5	External foot width: 9	

NB: Note any discrepancies

* Illustrations adapted from ISO16840-1 figures 26 and 31.

REF _____ CLIENT _____ DATE _____

GOAL SETTING – BASIC LEVEL

SECTION B4

Posture: _____

Pressure relief: _____

Accommodate deformity: _____

Accommodate joint limitations: _____

Relieve pain/increase sitting tolerance: _____

Allow for growth/weight gain: _____

Meet transportation/vocational/school needs: _____

Other: _____

Agreed goals: _____

Signed: (Assessor) _____

(Client) _____

Date: _____

PRODUCT CHARACTERISTIC RECOMMENDATIONS

SECTION B5

(Please tick or fill in the appropriate boxes)

Chair:

- Manual Powered
 Rigid Folding
 Self controlled Attendant controlled
 Seat width – cm Seat depth - cm Frame length S/Reg/L

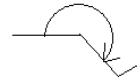
Foot supports:

- Foot bar Flip up
 Angle adjustable Std one piece composite Swing away

Any further additions (e.g. toe straps): _____

Hangers Angle:

- 240° 250° 260° 270° Other (specify): _____



Arm supports:

- Desk Full Adjustable

Rear Wheels:

- 10" 12" 16" 18" 22" 24" 26" Other (specify): _____

Tyre Chamber:

- Solid Pneumatic High pressure

Brakes:

- Push to lock Pull to lock Attendant brakes

- Castors:** Size: _____ cm Solid Pneumatic

Accessories (eg spokeguards, brake extensions, anti-tip devices etc): _____

Powered: Range Required: _____
 Terrain: _____
 Controller Option: _____

- Drive:** Front Mid Rear

Seating: Cushion: Width _____ cm Depth _____ cm Thickness _____ cm
 Planar Contoured

Back Support: Height: min _____ cm; max _____ cm
 Angle adjustable back support
 Tension adjustable back support Other
 Define: _____

FUNDING - SECTION B6

Sources of Funding	Yes/No	Contact Name	Title	Tel No
NHS				
NHS Voucher Scheme:				
Type – IDP/Partnership				
Private Purchase				
Charity				
Employment Service				
Other: (Specify)				
email				

PRODUCT TRIALS AND OUTCOMES – SECTION B7

	Date	Manufacturer	Model	Size	Options	Outcome
1. Wheelchair	1.1					
	1.2					
	1.3					
	1.4					
2. Cushion	2.1					
	2.2					
	2.3					
	2.4					
3. Back Support	3.1					
	3.2					
	3.3					
	3.4					
4. Accessories	4.1					
	4.2					
	4.3					
	4.4					
	4.5					
	4.6					

GUIDANCE NOTES ON COMPLETION OF THE RISK ASSESSMENT SECTION

SECTION B8

1. Column A lists the areas for the Client, Wheelchair, and Transportation for which a risk assessment should be carried out.
2. In Column B summarise the identified risk(s).
3. **Risk Likelihood:** In Column C place a score from 1 to 10 of the likelihood of the risk occurring, with 10 being the score for a high likelihood.
4. **Consequence:** In Column D score the consequence from 1 to 10 from the risk occurring, e.g. degree of injury, with 10 reflecting the worst consequence, e.g. death
5. In Column E multiply the scores from Columns C and D. If the score in this column is 20 or greater, then action will probably be needed to be taken to reduce the risk.
6. Column F should be used to summarise the actions to be taken to eliminate or reduce the identified risk. *Remember: a) more than one area of risk may be identified during an assessment, particularly when an assessment is being undertaken on a 'complex' client, and b) if the risks identified are complex, it may be necessary to undertake a more comprehensive risk assessment.*

Risk Assessment					
A	B	C	D	E	F
	Area Identified	Risk Scale 1-10	Harm Scale 1-10	Risk (Multiply C by D)	Risk Management
Client					
Client size / shape					
Physical / Cognitive and behavioural areas					
Abnormal tone / spasm					
Restraint					
Transfers					
Pressure Care					
Wheelchair					
Current condition and Heavy Use					
Stability					
Environmental issues - Internal					
Environmental issues - External					
Transportation					
Storing the wheelchair					
Travels in the wheelchair					
Other					
Hand-over / Training					
Carer Issues					

CLIENT _____ REF _____ DATE _____

FINAL PRESCRIPTION

	Manufacturer	Model	Size (W & D)	Options	Part No(s)
1. Wheelchair Type				1)	
				2)	
				3)	
				4)	
				5)	
				6)	
				7)	
				8)	
				9)	
				10)	
				Price:	
2. Cushion				1)	
				2)	
					Price:
3. Back Support				1)	
				2)	
					Price:
3. Accessories				1)	
				2)	
				3)	
				4)	
				5)	
				6)	
				Price:	

Total Price: _____

Signed: (Assessor) _____

Print: _____

Date: _____

Signed: (Client) _____

Print: _____

Date: _____

N.B. Attach manufacturer's prescription Form