

Medical Information

Review the prescription letter from the doctor, if available, to determine the diagnosis and impairment history. If there is no prescription, indicate your case impression and interview the wheelchair user and/or the attendant about the impairment history.

MEDICAL INFORMATION:

Diagnosis:	SCI T10 complete	Case impression:	
Impairment history:	Vehicular Accident year 2000		

Other Health Issues

Ask other health issues that may affect the use of wheelchair. Check all buttons and check boxes that apply.

OTHER HEALTH ISSUES:

Breathing Seizure Hip problems Bowel problems Bladder problems Pain Skin diseases
 Recent surgery Planned surgery Other please specify:

Does the wheelchair user take any medication? Yes No If yes, please specify:

Sensation

Check the wheelchair user's sensation (light touch and pressure) around the wheelchair user's sit bones, tailbone, hip bones, under the thighs, and side of thighs. Note any history of pressure sore. Recommend a pressure relief cushion for any indications that the wheelchair user has a risk of developing pressure sore. Such indications, include, but are not limited to:

- Decrease sensation at seat surface
- Age
- Pressure
- Limited or restricted mobility
- Expected compliance for pressure relief
- Urinary incontinence
- Overall health
- Moisture
- Heat
- Weight
- History of Pressure sore
- Fidgety

If the wheelchair user has no sensory impairment and there is no other risk factor in developing pressure sore then recommend a comfortable flat cushion.

SENSATION:

Does the wheelchair user have any sensory impairment at seat surface? Yes No
Does the wheelchair user have/had pressure sore? Yes No

Equipment

Ask if the wheelchair user has or had a wheelchair in the past?

NOTE: What were the major limitations and shortcomings of the previous wheelchair? What dangerous situations have occurred related to wheelchair use? Experienced wheelchair users usually know what's best for them.

The devices or equipment refers to orthoses, prostheses, and other medical devices presently used by the wheelchair user that will possibly be accommodated when he/she sits.

EQUIPMENT:

Does the wheelchair user have/had a wheelchair? Yes No

Does the wheelchair user have any additional assistive devices or medical equipment?

Prosthesis Orthosis Catheter Other please specify:

Will these devices or equipment be used while in the wheelchair? Yes No

Environment

Check the type of terrain and physical barriers that could prevent the user from freely navigating at home, school and/or workplace.

NOTE: Check basic things at home that may need modifications such as doorknobs, faucets, switches, sink, tables and other equipments they need to operate while on wheelchair.

ENVIRONMENT:

Terrain: Smooth Rough Sandy Hilly Other please specify:

Are there any physical barriers that will affect wheelchair use in the home and community? Yes No

Can the wheelchair user operate or reach household fixture and furniture? Yes No

Functional Abilities

Assess user's ability to sit. If he/she cannot sit without support, determine the level of support while simulating wheelchair backrest starting from pelvis to upper trunk and note the level of support as minimal, moderate and maximum. The data is useful in determining the backrest height of wheelchair.

NOTE: If the user has poor head control an all terrain wheelchair may not be appropriate.

How long the wheelchair user can sit without feeling dizzy or any kind of discomfort. This serves as a baseline on how long the wheelchair user should stay on wheelchair during and after fitting.

NOTE: Advise wheelchair user and/or attendant to gradually increase the time of sitting.

Check wheelchair user's ability to independently transfer from wheelchair to chairs, table, toilet and back. If the wheelchair user cannot transfer independently indicate the level of assistance required in minimum, moderate or maximum.

One way to assess self-propulsion is to let the wheelchair user sit on a wheelchair and let him try it. If a wheelchair is unavailable, make an intelligent guess based on the wheelchair user's upper and lower extremity strength, range of motion, and coordination.

Check wheelchair user's ability to relieve pressure such as leaning forward, sideward and sitting push ups.

Indicate how the wheelchair user communicates.

Check wheelchair user's vision and hearing it may affect the wheelchair user's ability for a safe wheelchair use.

FUNCTIONAL ABILITIES:

Sitting Balance - Can the wheelchair user sit without support? Yes No

If wheel user can not sit without support what level does he/she needs support?

Pelvic Level Lower Trunk Mid Trunk Upper Trunk Head

Degree of assistance: Minimum Moderate Maximum

Sitting tolerance: <15min(Poor-) 15-30min(Poor+) 30-40min(Fair) 45-60min(Fair+) >60min(Good)

Can the wheelchair user transfer independently? Yes No

Can the wheelchair user self propel? Yes No

Can the wheelchair user perform pressure relieving exercises? Yes No

Communication: Verbal Gesture Other please specify:

Vision: Normal Impaired Non-seeing

Hearing: Normal Impaired Non-hearing

Activities of Daily Living (ADL)

Check wheelchair user's activities of daily living that could be integrated on wheelchair use.

ACTIVITIES OF DAILY LIVING:

Eating: Independent Dependent
Dressing: Independent Dependent
Toileting: Independent Dependent
Personal Hygiene: Independent Dependent

Referral to Other Services

Refer wheelchair user for intervention to professionals for other needs identified during the assessment.

REFERRAL TO OTHER SERVICES:

Physical Therapist
 Occupational Therapist
 Prosthetist & Orthotist
 Social Worker
 Medical Doctor
 Special Educator
 Other please Specify:

Mat Assessment

Perform the mat assessment from head to ankle joint. Indicate the side of extremity being assessed, joint and motion if there is a limitation that may affect neutral sitting (eg; right trunk lateral flexion). Indicate if there is tightness or contracture. Leave the text box blank if the joint is flexible and within normal range of motion.

Under the "Sitting Posture" section, note any postural deviations during postural observation while the user is sitting with minimal support (eg; right posterior pelvic tilting).

Indicate the needed postural support devices to correct or accommodate any postural deviations.

MAT ASSESSMENT

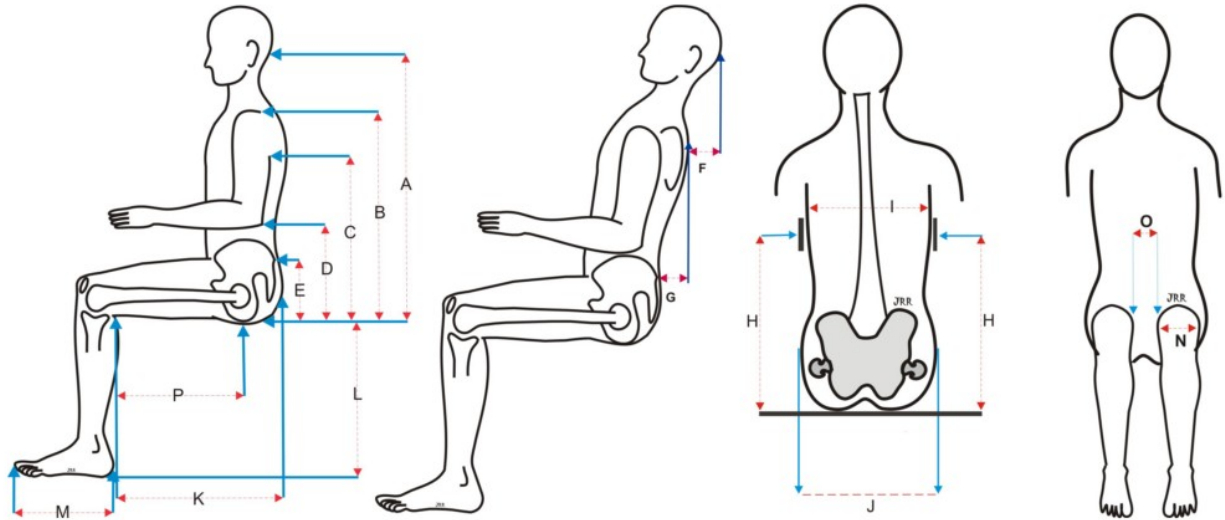
Parts	Side & Motions (e.g.right flexion)		Sitting Posture	Postural Support Device
Head & Neck	<input style="width: 150px; height: 30px;" type="text"/>	<input type="radio"/> Tightness <input type="radio"/> Contracture	<input style="width: 100px; height: 30px;" type="text"/>	<input style="width: 100px; height: 30px;" type="text"/>
Shoulders	<input style="width: 150px; height: 30px;" type="text"/>	<input type="radio"/> Tightness <input type="radio"/> Contracture	<input style="width: 100px; height: 30px;" type="text"/>	<input style="width: 100px; height: 30px;" type="text"/>
Trunk	<input style="width: 150px; height: 30px;" type="text"/>	<input type="radio"/> Tightness <input type="radio"/> Contracture	<input style="width: 100px; height: 30px;" type="text"/>	<input style="width: 100px; height: 30px;" type="text"/>
Pelvis	Right lateral tilt	<input checked="" type="radio"/> Tightness <input type="radio"/> Contracture	Right lateral pelvic tilt	Cushion build up
Hips	<input style="width: 150px; height: 30px;" type="text"/>	<input type="radio"/> Tightness <input type="radio"/> Contracture	Left hip flexion	<input style="width: 100px; height: 30px;" type="text"/>
Ankles	Left plantar flexion	<input type="radio"/> Tightness <input checked="" type="radio"/> Contracture	Left ankle plantar flexion	EVA
Knees	<input style="width: 150px; height: 30px;" type="text"/>	<input type="radio"/> Tightness <input type="radio"/> Contracture	<input style="width: 100px; height: 30px;" type="text"/>	<input style="width: 100px; height: 30px;" type="text"/>

BODY MEASUREMENT

Fill out body measurement part and convert it to seat dimension recommendations using the standard conversion formula. There is no need to fill-in the shaded area. See examples on the next page.

- A. **Occipital Shelf**—Measured perpendicularly from the occipital tuberosity to top of seat.
- B. **Shoulder Height**—Measured perpendicularly from seat to top of shoulder. Add one inch (1") to the shoulders' height to determine backboard's height.
- C. **Axilla Height**—Measured perpendicularly from seat to armpit. Minus one inch (1") to determine the maximum height of lateral trunk support. It may be lower than the actual dimension when the user sits with posterior pelvic tilt or trunk forward flexion.
- D. **Elbow Height**—Measured perpendicularly from the lower tip of a flexed elbow joint to top of seat.
- E. **PSIS**—Measured perpendicularly from the PSIS to top of seat.
- F. **Head to Trunk Offset**—Horizontal distance between head and trunk
- G. **Pelvis to Trunk Offset**—Horizontal distance between pelvis and trunk
- H. **Height of Lateral Trunk Support**—Seat to top of desired lateral trunk support.
- I. **Trunk Width**—In some cases trunk may be wider than the hip, add one inch (1") to determine the seat width dimension of the seating frame. Supportive seating wheelchair comes in either 12" or 14" seat width.
- J. **Hip Width**—Measured between the widest parts of the hips using the hip bones as bony landmarks. To determine the seat width dimension of wheelchair add one inch (1") to the wheelchair user's hip width.
- K. **Upper Leg Length**—Measured from back of buttocks to back of knee. Subtract one inch (1") to determine the seat depth.
- L. **Lower Leg Length**—Measured perpendicular from back of knee to sole of the foot or sole of everyday footwear. Footrest height is the distance from the front top of seat cushion to top of footrest. Footrest height is equal to wheelchair user's lower leg length.
- M. **Foot Length**—Measured from back of heel to front of longest toe or length of footwear. Fixed at 7" and it should support well an average Filipino foot length but if more foot support is needed indicate it in additional details part for possible modifications. You can choose to have a footrest or none.
- N. **Knee Width**—Measured between medial to lateral side of knee
- O. **Knee to Knee**—Measured between the medial side of knees
- P. **IT Location**—Measured from the center of IT to back of the knee and less three inches (3") to provide two inches (2") space from IT to pre-ischial shelf and one inch (1") from front tip of cushion to back of lower leg.

BODY MEASUREMENT:



BODY MEASUREMENTS AND RECOMMENDATIONS

Body Parts	Description	Body Measurement	Standard Conversion	Seat Dimension Recommendation
A. Occipital Shelf	Seat to Occipital	15	=	Head rest height 15
B. Shoulder Height	Seat to top of shoulder	13	+ 1 =	Back board height 14
C. Axilla Height	Seat to armpit	12	- 1 =	Maximum height of lateral trunk support 11
D. Elbow height	Seat to elbow (flexed at 90 degree)	6		
E. PSIS	Seat to PSIS	4	=	Sacral pad height 4
F. Head to trunk offset	Horizontal distance between head and trunk	1	=	Headrest location
G. Pelvis to trunk offset	Horizontal distance between pelvis and trunk	1	=	Sacral pad thickness 1
H. Height of lateral trunk support	Seat to top of desire lateral trunk support	8	=	Lateral trunk height 8
I. Trunk Width	Widest part of trunk	8	+ 1 =	Lateral trunk support wide 9
J. Hip Width	Between greater trochanters	8	+ 1 =	Side width 9
K. Upper Leg Length	PSIS to back of knee	9	- 1 =	Seat depth 8
L. Lower Leg Length	Back of knee to heel of the sole (plus thickness of foot wear if applicable)	8	=	Footrest height 8
M. Foot Length	Back of heel to front of toe	4	=	Footrest board length
N. Knee Width	Medial to lateral side of knee	2		
O. Knee to Knee	Distance between knees	3	=	Medial thigh support thickness 3
P. IT Location	Front of IT's to back of knees	7	- 3 =	Pre-Ischial shelf length 5

Other recommendations

Please check the appropriate box if additional recommendation is needed.
In deciding on the type of cushion, recommend pressure relief cushion for any indication in developing pressure sore.

NOTE: The pressure relief cushion does not substitute the need to perform pressure relieving exercises.

H. Seat Cushion	<input type="radio"/> Comfortable flat	<input checked="" type="radio"/> Pressure relief
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Axle Position

Measured from the front of the axle to rear of the axle.

- First axle position decreases the distance between rear axle and front caster.
- Third axle position is standard.
- Fifth axle position provides maximum stability because it increases the wheel base.

I. Axle Position	<input type="radio"/> First	<input type="radio"/> Second	<input checked="" type="radio"/> Third	<input type="radio"/> Fourth	<input type="radio"/> Fifth
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Backrest Cushion

Thickness can be 1" or 2" inches. Backrest cushion is optional. Check none if not required.

J. Backrest Cushion	<input type="radio"/> 1"	<input type="radio"/> 2"	<input checked="" type="radio"/> None
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Rear Tires

Supportive Seating Wheelchair rear tires has mountain bike tire.

K. Rear Wheel	<input checked="" type="radio"/> MTB
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Color

Supportive Seating Wheelchair is color yellow.

L. Color	<input type="radio"/> Yellow
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Additional Details

Additional Details. (Please specify)

flex foam 14" x 16"

Wheelchair User's Informed Consent

Have the wheelchair user and/or attendant read the informed consent form clause, Have wheelchair user and/or attendant tick the box and sign the photo consent once the wheelchair user and/or attendant agree. Take a front and side view photograph of wheelchair user in the seated position. See the examples below.

WHEELCHAIR USER'S INFORMED CONSENT

Freedom Technology Wheelchair, Inc. (FTWFI) requests your permission to use your photograph and personal information for the general mission of promoting the empowerment of persons with disabilities. Your photograph and personal information may be used, but not limited to, archiving, communication with other organizations, and educational and/or promotional materials.

Declining permission in no way will affect Freedom Technology Wheelchair, Inc. FTWFI from providing appropriate and quality service or your current or future involvement with Freedom Technology Wheelchair, Inc. FTWFI.

Permission maybe rescinded at any time.

I hereby grant Freedom Technology Wheelchair, Inc. (FTWFI) permission to use personal information and my photograph.

Wheelchair User's Printed Name:

Wheelchair User's Signature:

Date:

If wheelchair user is under 18 years of age the legal guardian must witness this document authorizing permission for Freedom Technology Wheelchair, Inc. (FTWFI) use the wheelchair user's personal information and photograph.

Guardian's Printed Name:

Guardian's Signature:

Date:

Wheelchair Clinician's Information and Informed Consent

WHEELCHAIR CLINICIAN'S INFORMED CONSENT

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Permission maybe rescinded at any time.

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Clinician's Name:

Clinician's Signature:

Date:

Send the Supportive Seating Assessment Form and photos with scanned photo consent form showing the signature through email: freedom.technology@yahoo.com.ph or mail at: Freedom Technology PHIVIDEK Estate, Sta. Cruz, Tagoloan, 9001, Misamis Oriental, Philippines.

Please do not hesitate to contact Freedom Technology if you have questions or need assistance at phone number +63 (08822) 742 702.

Thank You,

Freedom Technology Wheelchair Foundation Inc. Team

