

Acute Seating Assessment Form



Cork University Hospitals Group
Occupational Therapy Dept.

CLIENT INFORMATION

Name	Place Hospital Sticker Here		Consent to Assessment	Yes <input type="checkbox"/>	Obtained from	Client	NOK	Parent
MRN		D.O.B.	Photographic Consent	Yes <input type="checkbox"/>	Obtained from	Client	NOK	Parent
			Assessment Date		Funding Details	Medical Card; Insurance; Private		

Diagnosis								
Medical Considerations								
Prognosis/ Plan					GCS/ Alertness			
Cognition/ Perception	NAD	Concerns Exist		Is patient aware of concepts				
Behaviour	NAD	Concerns Exist		Requires Supervision				
Reason for Referral								
Current Seating System	Type & dimensions of seating & cushion							
Difficulties with current seating								

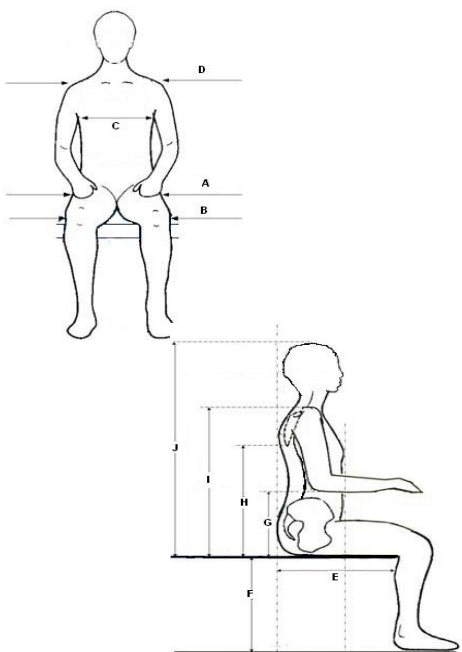
GOALS FOR SEATING / OT INTERVENTION

Transport/ Mobility		Spinal Cord Injury (Complete T3-4 & Above)
Medically Unwell- Temporary Solution		Complex Age Related Postural Deficits/ Contractures
Promote Respiratory/ Postural Response		Lower Limb Amputation (BKA/ AKA)
Pressure care/ redistribution		Lower Limb Contractures
Comfort		Significant Traumatic Brain Injury
Rehabilitation/ Graded Sitting Programme		Complex Neurological Deficits with associated postural & positional changes (Stroke, MS, etc)
 Complete acute seating assessment & provide advice		Consider Comprehensive Wheeled Mobility & Posture Management Assessment

Other:

FUNCTION	Mobility & Falls: Mobility: Aids: Hx of falls: Precautions (if any): Continence: Bladder Continent Incontinent Bowel Continent Incontinent	Transfer Method: <input type="checkbox"/> Independent <input type="checkbox"/> Ind. with equip <input type="checkbox"/> Assistance x 1 <input type="checkbox"/> Assistance x 2 <input type="checkbox"/> Dependent Equipment: Transfer board, Hoist	Pressure Risk: Scale Used: Score: Pressure Ulcer: <input type="checkbox"/> Current <input type="checkbox"/> History <input type="checkbox"/> Nil Ulcer Grade: I II III IV Location: Sacrum, IT, Spinal Processes, Heels, Occiput, Other	Environment: <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Other: _____ <input type="checkbox"/> School _____ <input type="checkbox"/> Transport _____ <input type="checkbox"/> Other _____
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REVIEW IN SITTING (note relevant measurements)

MEASUREMENTS		Weight	st/lb	kg
		Height	ft/in	m/cm/mm
		A Hip Width (Widest Point)		
		B External Knee Width (Width across knees)		
		C Chest Width		
		D Shoulder Width		
		E Thigh Depth (Sacrum to popliteal fossa)	Left	Right
		F Lower Leg Length (Popliteal fossa to heel)	Left	Right
		G Elbow Height (Seat surface to hanging elbow)	Left	Right
		H Scapula Height (Seat surface to inferior angle of scapula)	Left	Right
		I Shoulder Height (Seat surface to shoulder)		
		J Maximum Sitting Height (Seat surface to top of head)		
		K Trunk Depth (For backrest style & thoracic laterals)		
		Backrest to stump end (extended knee)	Left	Right
		Stump Width	Left	Right
Other				

SITTING ABILITY	Current Sitting	Function	Alertness/ Behaviour	Tolerance/ Fatigue
	<u>Hx of falls from chair?:</u>	Independent; shift weight outside base of support	No issues identified	Unlimited; shifts position as required
	<u>Current chair:</u>	Hands free with ability to shift weight within base of support	Minimal Issues identified	Able to shift weight but tires within 3 hours
	<u>Usual time sitting out:</u>	Hands free sitting only; unable to shift position	Not agitated, does not wander, compliant, "Pleasantly"/mild Confusion	Unable to change position/ tires within 1-2 hours
	<u>Precautions & concerns (if any):</u>	Propped with hands supporting	Non compliant, wanders, requires special	Tires within less than 1 hour
Dependent / needs external support		Low GCS	No Tolerance/Tires within minutes	

SITTING POSTURE		Please Circle...			Guidance	Joint Range Limitations/ Postural Variations
	Pelvis	NAD	Minor Deficit	Major Deficit	Is the pelvis level/neutral? Do they lean to one side? Is the patient able to sit as far back as possible? Ensure there is no anterior tilt, posterior tilt or lateral rotation / obliquity	
	Trunk	NAD	Minor Deficit	Major Deficit	Is the patient sitting up straight? Is there kyphosis? Leaning forward? Leaning to one side?	
	Head & Neck	NAD	Minor Deficit	Major Deficit	Is the patient able to centre their head? For how long can the patient maintain head support?	
	Lower Limbs	NAD	Minor Deficit	Major Deficit	Does the current seating provide stable base for sitting? Are the feet able to be supported with the ankles at neutral? Can the patient flex hips to 90 degrees?	
	Upper Limbs	NAD	Minor Deficit	Major Deficit	Can patient move hands freely? Is the patient holding onto the chair for stability?	
	Weight Distribution	NAD	Minor Deficit	Major Deficit	Does the patient evenly distribute weight between both sides of their buttocks and thighs? Do they lean to one side? Is weight distributed through their feet, arm supports, backrest, or headrest?	
Photos Taken		Details, Orientation				

RISK ANALYSIS	Do Risk Management Issues Exist?		No	Yes	Please specify intent of use?
	Are Enabler &/Or Restraint Devices in Use/Required? If Yes, please refer to your local policy			

SUMMARY OF CRITICAL CONSIDERATIONS (Incl. Client Expectations / Goals & Treatment Goals)

PRESCRIPTION / RECOMMENDATIONS

Type of Seating System	Ward Chair Comfort Transit/ Self-Propelled Wheelchair Tilt-in-space Nursing Seating Specialised Postural Management Equipment Name: _____ Size required: _____		
Type of Cushion	Low Medium High Name: _____ Size required: _____		
Additional Supports/ Accessories	Pelvic Safety Belt; Pelvic Positioning Belt; Tilt-in-Space; Recline; Antitippers; Lateral Supports		
Sitting Tolerance Regime	30 mins; 1 hour; 2 hours; 3 hours; As tolerated by informed patient		
Postural Advice	Requires equipment; physical prompting; verbal prompting; General; Education; No advice required		
Risk Management Issues	Use of Enabler/Restraint; Intent of Use		
Signature	Printed Name	Title	Date

Name of Client: _____

MRN: _____

D.O.B.: _____

SEATING REVIEW

Client Name:		MRN:		Location:	
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Identify any changes to the patients function/needs and/or those made by the clinician:

Date:									
Sitting Function									
Alertness/ Behaviour									
Tolerance/ Fatigue									
Sitting Posture									
Sitting Regime (Time & Frequency)									
Chair									
Cushion									
Other (Please State)									
Signature									

Name of Client:

MRN:

D.O.B.: