Ron Joyce Children's Health Centre
Adult Complex Wheelchair and Seating Clinic
325 Wellington Street North, Hamilton, ON,
905-521-2100 extension 77128

ADULT COMPLEX WHEELCHAIR & SEATING CLINIC
PHYSICIAN REFERRAL FORM

CLIENT NAME: _____

ADDRESS: _____

POSTAL CODE: _____ PHONE: _____

DATE OF BIRTH: ____/____/____ HEALTH CARD # _____
D M Y

DIAGNOSIS/PERTINENT MEDICAL INFORMATION: _____

_____

ONSET/PROGRESSION/PROGNOSIS: _____

OTHER RELEVANT HEALTH INFORMATION: (include concerns with skin integrity, pain, postural tendencies, spasticity, allergies & medications which may affect seating prescription) _____

_____

REASON FOR REFERRAL : _____

_____

MEDICAL DIRECTIVE: OCCUPATIONAL THERAPIST TO ASSESS AND TREAT AS REQUIRED

Physician Name (PRINTED): _____

Address: _____ Postal Code: _____

Phone: _____ Fax: _____

Physician Signature: _____ Date: _____

This Physician Referral Form (1 page) and all 2 pages of Client Information Form must be completed in full before application will be reviewed.

Return to: Intake Office
Hamilton Health Sciences, Regional Rehabilitation Centre
237 Barton St. East, Bldg. 2
Hamilton ON L8L 2X2
Phone: (905) 521-2100 ext. 40806 FAX: (905) 521-2359

Hamilton Health Sciences
Ron Joyce Children's Health Centre
Adult Complex Wheelchair and Seating Clinic
325 Wellington Street North, Hamilton, ON,
905-521-2100 extension 77128

ADULT COMPLEX WHEELCHAIR & SEATING CLINIC
CLIENT INFORMATION FORM

NAME _____ PHONE_____

ADDRESS_____CITY_____POSTAL CODE_____

DATE OF BIRTH _____/_____/_____ HEALTH CARD NUMBER_____
D M Y

FAMILY PHYSICIAN _____ PHONE_____

CONSENT

I consent to the following (please check appropriate boxes and sign below),

1. Completion of an assessment by an Occupational Therapist with the assistance and assignment of tasks to an Occupational Therapist Assistant NO ☐ YES ☐
2. Sharing of personal information with my chosen vendor, seating technician and equipment suppliers NO ☐ YES ☐
3. Communication of information via EMAIL, acknowledging that although all efforts are made to ensure confidentiality, it cannot be guaranteed. NO ☐ YES ☐

   If yes, provide email address: _____

Signature	**Date**
Name(please print)	

If above signature is not that of the client, specify relationship to client and fill out contact information

Spouse ☐ Parent ☐ Legal Guardian ☐ Public Trustee ☐

Do you have power of attorney for: Finances ☐ Personal care ☐

PLEASE PRINT

NAME: _____

ADDRESS: _____CITY:_____

POSTAL CODE: _____ PHONE NUMBER: _____

CURRENT EQUIPMENT

VENDOR CHOICE _____

Do you need further information and/or a vendor list to determine vendor choice? NO ☐ YES ☐

COMMUNITY THERAPIST Do you have a community therapist currently working with you? NO ☐ YES ☐
(If yes please complete below information)

THERAPIST'S NAME _____

AGENCY _____ PHONE _____

EQUIPMENT (If any equipment has been purchased with funding assistance from the Assistive Devices Program (ADP), please call ADP to obtain information on your most recent equipment funding date – this is used to help plan for future funding applications to ADP. **Call ADP at 1-800-268-6021,** you will be asked for your health card number to receive the information.)

Wheelchair: Last ADP funding date**:** _____

Type of wheelchair: ☐ Manual_____ ☐ Power_____
Make/Model Make/Model

Dynamic Seating Components (check all that apply):

☐ Manual tilt ☐ Manual recline ☐ Manual elevating leg rests

☐ Power tilt ☐ Power recline ☐ Power elevating leg rests

Seating Components: Last ADP funding date**:** _____

Back rest name: _____

Cushion name: _____

Reason for Referral to the Complex Wheelchair and Seating Clinic (Issues and Concerns with current seating and mobility system (check all that apply):

☐ **Current pressure/skin breakdown:** Please identify location and stage of wound _____

☐ Posture ☐ Mobility ☐ Spasticity ☐ Pain/comfort ☐ Condition of equipment

☐ **Other Concerns:** _____

All 2 pages of this form AND Physician Referral Form (1 page) must be completed in full before application will be reviewed.

Return to: Intake Office
Hamilton Health Sciences, Regional Rehabilitation Centre
237 Barton St. East, Bldg. 2
Hamilton ON L8L 2X2
Phone: (905) 521-2100 ext. 40806 Fax: (905) 521-2359