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| **LEVEL 2 WHEELED MOBILITY & POSTURAL MANAGEMENT CASE STUDY ASSESSMENT FORM** |

*Complete form fully & refer to guidelines on Seating To Go website: www.seatingtogo.co.nz*

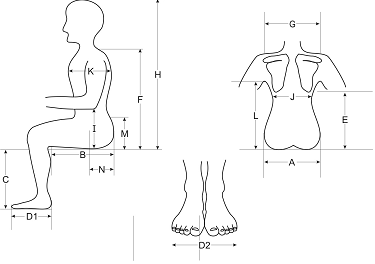
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| **NAME:** \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age:** \_\_\_\_\_ **Male  Female**  *(First name only)* | | | |
| **ASSESSOR:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **REASON FOR RE/ASSESSMENT:** | **Other Health & Disability Providers:** | | |
| **CLIENT’S DESIRED OUTCOME OF INTERVENTION:** | | | |
| **DIAGNOSIS** *(include primary & secondary, symptoms)*  **Improving  Stable  Deteriorating**  **GMFCS Level** *(if applicable)* | **MEDICAL & SURGICAL HISTORY** *(include planned)* | | |
| **ROLES, RESPONSIBILITIES & RELATIONSHIPS** | | | |
| **SOCIAL: Lives alone  Lives in aged residential care  Lives with others**  Describe:  **Key relationships:** *(people who are important to the person)*  **Funded support at home? YES  / NO** *Type & Hours if applicable:* | | | |
| **Responsibilities & tasks** that are important to the person **around the home:**  *(Meal prep, caring for others, housework)* | | | |
| **Responsibilities & tasks** that are important to the person **in the community:**  *(shopping, visiting friends & family, church, Marae, paying bills)* | | | |
| **Work or education roles** *(include voluntary & hrs/wk):*  **Funded support at school? YES /NO**  *Type & Hours if applicable:* | | | **Hobbies & interests:** |
| **WHEELED MOBILITY & POSITIONING PARAMETERS WHICH COULD IMPROVE/MAINTAIN PARTICIPATION:** | | | |
| **MANAGING DAY TO DAY TASKS** | | | |
| **MOBILITY:** Assisted for all mobility  Wheelchair use: Full time  Frequent  Occasional  Mobilises indoors  *How? Include floor mobility, walking aids used, & level of assistance.*  Mobilises outdoors  *How? Include walking aids used & level of assistance.* | | | |
| **PERSONAL CARE TASKS:** *(washing, dressing etc)*  Independent Assisted Dependent  **EATING:** Independent  Assisted NG /PEG | **INCONTINENCE MANAGEMENT:** N/A  Catheter *Indwelling* */ intermittent* */ suprapubic*  Uritip Bottle Colostomy Wears product  Other requirements: | | |
| **COMMUNICATION METHOD:**  **Methods used** *(tick all)*  Speech Written  Sounds  Eye gaze Gestures  Signs  Comm. Board Electronic device | **COMMUNICATION LEVEL:**  Effective Effective but slower paced  Inconsistent Seldom effective  **Recommend joint technology appt** | | |
| **HAND FUNCTION: Dominant hand R  / L**  Handles objects easily & successfully  Likely to require adapted equipment.  *(pushrims, joystick knobs, auxillary switch for mode)* | Comment on quality of hand function/needs: | | |
| **WHEELED MOBILITY & POSITIONING PARAMETERS WHICH COULD IMPROVE/MAINTAIN FUNCTION:** | | | |
| **HOME ENVIRONMENT & COMMUNITY ACCESS** | | | |
| **Home / housing:** Own  Private rental  Housing NZ  Residential care  **Access issues/requirements at home:** N/A  Recommend referral to housing assessor  **Access issues/requirements at education / workplace:** N/A  May require joint MOH/MOE funding | | | |
| **TRANSPORT:** **Drives** : *in std seat*   *from wheelchair*  Pending driving lessons/assessment  **Uses public transport** :  *bus*  *taxi*  **Passenger** : *in std seat*  *in child’s carseat*  *in wheelchair*  **Transportation of wheelchair:**  Manually lifted : *by client*  *other*  Platform hoist  Lifting device  (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight limit of lift\_\_\_\_\_\_\_\_  Own vehicle type & age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Anticipated future transport needs: *(e.g. consider restraint system, transferring ability)* Liaise with Transport assessor | | | |
| **WHEELED MOBILITY & POSITIONING PARAMETERS WHICH COULD IMPROVE/MAINTAIN ACCESS:** | | | |
| **KEEPING SELF & OTHERS SAFE** | | | |
| **History & risk of injury** – self & carers | **Swallowing**: Normal  Impaired | | |
| **Hearing**: Normal  Impaired Uses aid | | |
| **Vision:** Normal  Impaired  Diagnosis: | | |
| **Transfers:** Indep  Board Hoist Assist  **Endurance:** Normal  Impaired Deteriorating | **Cognition, perception & behaviours** – *observations, risks, possible challenges for wheelchair use* | | |
| **Pressure care:** *Consider pressure mapping for chronic pressure related injuries*  Risk assessment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Score:\_\_\_\_\_  Areas of compromised **skin integrity**:  Contributing factors / comments:  Pressure care equipment in situ: | Areas of **pain:**  Contributing factors / comments: | | |
| **Ability to redistribute pressure / change position:**  Independent  Needs assistance  Method/frequency: | | |
| **PRECAUTIONS RELATED TO POSITIONING:** (*e.g breathing, reflux, temperature control, swallowing, pain, behaviour)*  **Indicate in which positions, risks are likely to be increased** *– supine, prone, side lying.* | | | |
| **WHEELCHAIR SKILLS:** *Do not complete this section if person is assisted for all mobility:*  Propulsion technique:  Describe capacity & safety to mobilise inside home: Manual wheelchair  Power wheelchair  Describe capacity & safety to mobilise around community: Manual wheelchair  Power wheelchair  Factors which limit ability: | | | |
| **WHEELCHAIR & POSITIONING PARAMETERS WHICH COULD IMPROVE/MAINTAIN SAFETY:**  **TRAINING NEEDS TO IMPROVE SAFETY:** | | | |
| **CURRENT WHEELED MOBILITY & POSTURAL MANAGEMENT EQUIPMENT:** *Includes sizes & date of issue* | | | |
| **Wheelchair/s:**  Time spent in wheelchair/day:  **Electronics & controls:**  **Back support:** *Include modular components*  **Cushion:** *Include modular components*  **Accessories:** *e.g. head supports, anterior chest supports, pelvic positioning belts, tray* | | **Lying equipment:**  **Alternative sitting equipment:**  **Standing equipment:**  **Orthotics:**  **Other interventions/activities undertaken to assist with physical management:** | |
| **TYPICAL POSTURE IN CURRENT WHEELCHAIR & SEATING:** | | | |
| *Draw or insert photo from* ***front*** *at seat pan level:* | *Draw or insert photo from* ***side*** *at seat pan level:* | | |
| **Indicate below, typical posture in current equipment:** | | | |
| **Pelvis:** Posterior tilt  Anterior tilt Neutral  Obliquity down L / R  Rotation to L / R | **Spine:** Scoliosis convex L / R  Kyphosis  Lordosis Neutral | | |
| **Lower limbs:** Abduction L / R  Adduction L / R  Int rotn L / R Ext rotn L / R Neutral L / R | **Shoulder girdle:** Protracted  Retracted  Rotated to L / R  Neutral | | |
| **Feet:** Dorsiflexed L / R  Plantarflexed L / R  Inverted L / R Everted L / R Neutral L / R | **Head & neck:** Fwd flexion  Lateral flexion L / R  Hyperextended Neutral | | |
| **Arms & hands:** Normal position & movement Other: | | | |

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| **NEUROLOGICAL PRESENTATION** | | | | | | | | | | | | | | |
| **TONE:** (predominant pattern):  NORMAL SPASTICITY DYSKINESIAHYPOTONIA ATAXIA | | | | | | | | | | | | | | |
| **DISTRIBUTION & OBLIGATORY MOVEMENT PATTERNS OBSERVED:** | | | | | | | | | | | | | | |
| Enter:  ↑ = hypertonic  Right Left ↓ = hypotonic  ↔ = fluctuating  N = normal  *NB: The purpose of this assessment form is limited to information to assist with providing supported lying/sitting positions. Refer also to the Australian Spasticity Assessment Scale for more detailed assessment of spasticity in cerebral palsy.* | | | | | | | | | | **Supine:** Obligatory movement patterns observed:  *(include laterality)*  What triggers these patterns?  What positions in lying inhibit these patterns? | | | | |
| **Sitting:** Obligatory movement patterns observed:  *(include laterality)*  What triggers these patterns?  What positions in sitting inhibit these patterns? | | | | |
| **LYING ABILITY & RECOMMENDATIONS: Complete ROM in supine lying before completing this section.** | | | | | | | | | | | | | |
| Describe usual position of sleep:  Are there issues with comfort or sleep disturbance?  Does the person present with persistent asymmetry and immobility in lying? Describe:  If yes to above, describe or photograph (birds eye & side views) recommended supported lying position: | | | | | | | | | | | **From assessment, supported lying positions are recommended for:**  Day time positioning  Night time positioning  **The purpose of providing supported lying positions are:**  Postural management  Pressure management  Improve sleep  Decrease manual handling  Maintain ability to manage personal cares | | |
| **SUPINE EVALUATION:** *Prior to assessment, align shoulder & pelvic girdle as able, support into some hip & neck flexion for people with increased tone or who are hard to mobilise. Passive range of movement (PROM) is assessed.* | | | | | | | | | | | |
| NAD = Nothing abnormal detected - has full PROM. | | | | | | | | | | | Describe requirements for 🡳 ROM & points of control needed for optimal positioning below: |
| **PELVIS & SPINE** – *assess further in sitting* | | | | | | | | | | |
| **TILT**  NAD | POST  ANT  NEUTRAL | |  | | FLEX  FIXED | | | |  |  | |
| **OBLIQUITY**  NAD  *(Down on…..)* | RIGHT  LEFT  NEUTRAL | |  | | FLEX  FIXED | | | |  |
| **ROTATION**  NAD  *(Towards the….)* | RIGHT  LEFT  NEUTRAL | |  | | FLEX  FIXED | | | |  |
| **SCOLIOSIS** NAD  *(Convex to…..)* | RIGHT  LEFT  NEUTRAL  **Rib cage distortion** | | | | FLEX  FIXED  **YES  NO** | | | |  |
| **HIPS Extension** → **Flexion**  Record PROM with pelvis in neutral tilt if achievable | | | | | | | | | | *The PROM recorded shows what is available for a seated position with pelvis in a neutral tilt (as able).* | |
| Normal ROM | 15° | * 0° | | | | 120° | | | |
| **RIGHT** |  | - ° | | | | - ° | | | |
| **LEFT** |  | - ° | | | | - ° | | | |
| **HIPS Abduction** →  **Adduction**  Measure with hips flexed for sitting | | | | | | | | | |  | |
| Normal ROM | 40° | * 0° | | | | * 30° | | | |
| **RIGHT** @ \_\_\_  *Hip flexion* | ° | - ° | | | | - ° | | | |
| **LEFT** @ \_\_\_*Hip flexion* | ° | - ° | | | | - ° | | | |
| **HIPS** | **Int Rot** → **Ext Rot**  Measure with hips flexed for sitting | | | | | | | | |  | | |
| Normal ROM | 40° | | | * 0° | | | * 45° | | |
| **RIGHT**@ \_\_\_*Hip flexion* | ° | | | - ° | | | - ° | | |
| **LEFT**@ \_\_\_*Hip flexion* | ° | | | - ° | | | - ° | | |
| **KNEES Extension** → **Flexion**  Measure with hips flexed for sitting | | | | | | | | | | 0° | | |
| Normal ROM | 0° | | | * 0° | | | | * 135° | | 90° | | |
| **RIGHT** @\_\_\_*Hip flexion* |  | | | - ° | | | | - ° | | 1135° | | |
| **LEFT** @ \_\_\_*Hip flexion* |  | | | - ° | | | | - ° | |  | | |

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| **SITTING EVALUATION (*ON FIRM SURFACE)*** | | | | | | | | |
| NB: DECREASED HIP FLEXION (<90°) MUST BE ACCOMMODATED BEFORE CONTINUING. Refer to ROM assessed in supine & aim for best achievable position that meets physical & functional needs, and individual preference. | | | | | | | | |
| NAD = Nothing abnormal detected - has full PROM. | | | | **FLEX** | | **FIXED** | | *Describe the seating features & points of control needed, to reduce / prevent further asymmetry and/or increase function.* |
| **PELVIS**  NAD | ANT/POST TILT | | |  | |  | |  |
| OBLIQUITY R/L | | |  | |  | |
| ROTATION R/L | | |  | |  | |
| **RIGHT HIP / LEG** | Given the range assessed in lying, comment on ***how*** the person will be positioned in sitting.  Hip Flexion: \_\_\_\_\_ Knee Flexion: \_\_\_\_\_  Abd / Add:\_\_\_\_\_\_ Int / Ext Rotn:\_\_\_\_\_\_ | | | | | | | *Describe/draw rationale for hip & knee positioning & key points of control:* |
| **LEFT HIP / LEG** | Given the range assessed in lying, comment on ***how*** the person will be positioned in sitting.  Hip Flexion: \_\_\_\_\_ Knee Flexion: \_\_\_\_\_  Abd / Add:\_\_\_\_\_\_ Int /Ext Rotn:\_\_\_\_\_\_ | | | | | | |
| **SPINE:**  Score spinal alignment: 0=normal posture, 1= flexible & fully reducible, 2 =limitation is structural but minimal, 3= limitation is structural & moderate, 4= limitation is structural & severe | | SCOLIOSIS L / R *(Convex to)*  *Score:* | | | *Draw* ***rear*** *or* ***side*** *view stick figure/s that show structural curves with shaded areas showing where structural bulk is situated in trunk. Include key points of control to manage any asymmetry…*  ***Laterals:***  *Height to top of upper lateral L / R:*  *Height to bottom of lower lateral L / R:* | | | |
| KYPHOSIS  *Score:* | | |
| LORDOSIS  *Score:* | | |
| **SHOULDER**  **GIRDLE**  NAD | PROTRACTED | | FLEX  FIXED | | | | |  |
| RETRACTED | | FLEX  FIXED | | | | |
| NEUTRAL | | FLEX  FIXED | | | | |
| ROTATED TO R / L | | FLEX  FIXED | | | | |
| **HEAD & NECK**  NAD | EXTN / FLEXN | | FLEX  FIXED | | | | |
| LAT FLEX TO R / L | | FLEX  FIXED | | | | |
| ROTN TO R / L | | FLEX  FIXED | | | | |
| **REQUIREMENTS FOR ARMS & HANDS:**  NAD | | | | | | | | **REQUIREMENTS FOR LEGS & FEET:**  NAD |
| **SITTING ABILITY** | | | | | | | | |
| Draw or photograph typical **unsupported** sitting posture on a plinth or box: | | | | | | | Draw or photograph recommended **supported** sitting posture on a plinth or box: | |
| **CHAILEY LEVEL OF SITTING ABILITY:**  1 -Unplaceable  2 - Placeable with full support  3 - Able to maintain sitting position without movement | | | | | | | 4 - Able to maintain sitting position & move within base  5 - Able to maintain sitting position & move outside base  6 - Able to move out of sitting position but not regain position  7 - Able to move out of sitting position & regain position | |

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| **MEASUREMENTS:** |

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| --- | --- | --- |
| **Date:** |  |  |
| **A** |  |  |
| **B (R)** |  |  |
| **B (L)** |  |  |
| **C (R)** |  |  |
| **C (L)** |  |  |
| **D 1** |  |  |
| **D 2** |  |  |
| **E (R)** |  |  |
| **E (L)** |  |  |
| **F** |  |  |
| **G** |  |  |
| **H** |  |  |
| **I (R)** |  |  |
| **I (L)** |  |  |
| **J** |  |  |
| **K** |  |  |
| **L** |  |  |
| **M** |  |  |
| **N** |  |  |



Height of person:

Weight of person:

Current seated height:

|  |
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| **ADDITIONAL MEASUREMENTS FOR SIGNIFICANT NON-REDUCIBLE ASYMMETRY:** |
| Overall width of severe scoliosis        **Front / Rear**    Overall width of fixed wind-sweeping    **To left / to right**  Custom lumbosacral block      Thigh to trunk angle:  L =  R =  Thigh to lower leg angle:  L =  R =  **Recommended seated angles** |

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| **IDENTIFIED PROBLEMS** | **IDENTIFIED NEEDS** |
|  |  |
| **GOALS (decided jointly with client & carers)**  **(Option is to use the Wheelchair Outcome Measure)** | |
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