Seating and Wheelchair Accessory Benefits
Seating Needs Level Eligibility Assessment Form

Protected A (when completed) Alberta Aids to Daily Living Program

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The Seating Needs Level Eligibility Assessment form MUST be completed for all authorization for AADL seating benefits. Complete all fields. Indicate "N/A" if not applicable to the client.

A) Client Information	
Name:	**Assessment Date:** *(dd-mm-yyyy)*
Personal Health Care Number:	**Date of Birth:** *(dd-mm-yyyy)*

B) Medical History

Diagnosis/Diagnoses:

Status: ☐ Stable ☐ Progressive

Comments:

Does the client have any short-term medical conditions that will affect this assessment? ☐ No ☐ Yes

Explain:

What are the client's expectations from the seating assessment and seating equipment?

Explain:

C) Functional Status

Wheelchair: ☐ AADL funded ☐ Privately funded ☐ Manual ☐ Power ☐ Tilt-in-space ☐ Recline

Make/Model/Size:

Wheelchair use: ☐ Independent ☐ Assisted ☐ Dependent **Consecutive hours used per day:**

Comments:

Transfers: ☐ Independent ☐ Assisted ☐ Dependent

Aids/considerations:

Ambulation status: ☐ Independent ☐ Assisted ☐ Dependent

Aids/considerations:

Activities of daily living: ☐ Independent ☐ Assisted ☐ Dependent

Aids/considerations:

Other adaptive equipment/technology:

D) Environmental Considerations

Client's residence:

Work/school:

E) Skin Integrity

Skin integrity during assessment: ☐ Intact ☐ Previous ulcers ☐ Red area ☐ Open area ☐ Scar tissue

Braden score (or equivalent):

Significant risk factors and strategies:

Comments:

F) Other Considerations

Cognitive status:

Hearing/vision:

Respiratory status:

Pain:

Other:

G) Posture/MAT Assessment

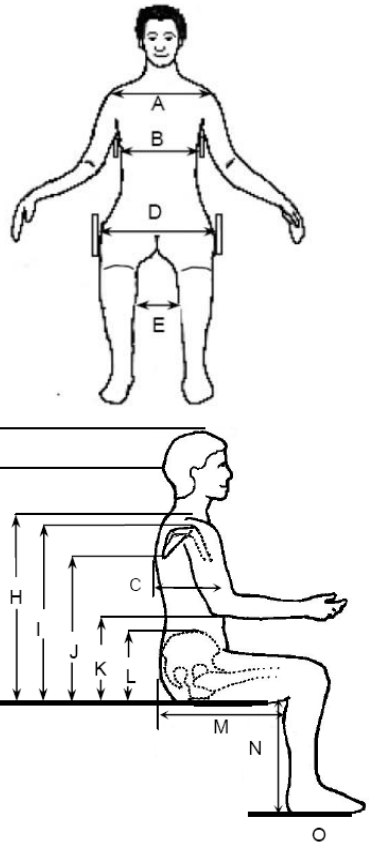
Level of Sitting Scale:

☐ 1 – Unplaceable
☐ 2 – Supported from Head Downward
☐ 3 – Supported from Shoulders or Trunk Downwards
☐ 4 – Supported at Pelvis
☐ 5 – Maintains Position, Does Not Move
☐ 6 – Shifts Trunk Forward, Re-erects
☐ 7 – Shifts Trunk Laterally, Re-erects

Spasticity:

Other postural consideration:

	Supine Lying Posture			Sitting Posture		
	Movement	**Measurement/ [Displacement/ROM]**	**Deformity [Fixed/Flexible]**	**Movement**	**Measurement/ [Displacement/ROM]**	**Deformity [Fixed/Flexible]**
Pelvis	Tilt:			Tilt:		
	Rotation:			Rotation:		
	Obliquity:			Obliquity:		
Trunk	Kyphosis:			Kyphosis:		
	Lordosis:			Lordosis:		
	Scoliosis:			Scoliosis:		
	Rotation:			Rotation:		
Hips	Flexion:			Flexion:		
	Abduction:			Abduction:		
	Adduction:			Adduction:		
	Internal Rotation:			Internal Rotation:		
	External Rotation:			External Rotation:		
Lower Extremities						
Head/ Neck						
Shoulders						
Upper Extremities						

	H) Seating Measurements			
A	Shoulder width			
B	Chest width			
C	Chest depth			
D	Hip width			
E	Between knees			
F	Top of head			
G	Occiput			
		Left	Right	
H	Top of shoulder			
I	Acromion process			
J	Inferior angle of scapula or axilla			
K	Seat to elbow			
L	Iliac crest			
M	Sacrum to popliteal fossa			
N	Knee to heel			
O	Foot length			Height:
	Degree of hip flexion			Weight:

Other measurements or postural assessment information:

I) **Seating Summary** *(attach additional pages if more space is required)*		
Team Members	**Occupational/Physical Therapist:**	**Occupational/Physical Therapist:**
	Seating Technician:	**Other:**

Client-centered SMART functional goals:

Seating Equipment	Clinical Justification

Seating Needs Level: ☐ Level A – Basic ☐ Level B – Specialized ☐ Level C – Complex

J) Authorizer Information

Name:		**Signature:**
Seating Team: ***(if required)***	**Authorizer #:**	

K) Client Acknowledgment

By signing below, the client (or caregiver) acknowledges that they:

- ☐ Have participated in the seating assessment and agree with the seating summary goals and equipment recommendations.
- ☐ Agree to take care of the equipment provided.
- ☐ Understand the limits of AADL funding for seating equipment.

Name:	**Signature:**	**Date:**

Provide a copy of this page to the client/caregiver.