

Name:

Date:

Client ID:

	Critical Measure	Guidance	Assessment Findings	Recommendations
1	<p>Hip Flexion</p> <p>Range (120/0/15)</p>	<ul style="list-style-type: none"> <li>* Influences position of pelvis (tilt, obliquity)</li> <li>* Need to assess bilaterally</li> <li>* Key to setting seat to back angle (amount of recline or is recline needed?)</li> </ul>	<p>Right:</p> <p>Left:</p> <p>Comments:</p>	
2	<p>Knee Extension with Hip Flexion</p> <p>Range (130/30/0)</p>	<ul style="list-style-type: none"> <li>* Influences position of pelvis (tilt and rotation)</li> <li>* Need to assess bilaterally</li> <li>* Accommodation of hamstrings is vital</li> <li>* Key to setting angle of foot hangers</li> </ul>	<p>Right:</p> <p>Left:</p> <p>Comments:</p>	
3	<p>Hip abd / adduction with hips flexed</p> <p>Range (80/0/20)</p>	<ul style="list-style-type: none"> <li>* Influences position of pelvis (rotation)</li> <li>* Ensure accommodation of any restriction as this will have severe implications for preventing a destructive postural tendencies</li> </ul>	<p>Right:</p> <p>Left:</p> <p>Comments:</p>	



	Critical Measure	Guidance	Assessment Findings	Recommendations
4	Cervical Flex / Ext  Range (40/0/40)	<ul style="list-style-type: none"> <li>* Important for visual field</li> <li>* Key for feeding position</li> <li>* Limitation in flexion can result in tilt in space being contraindicated</li> </ul>	Range:  Comments:	
5	Kyphosis / Scoliosis	<ul style="list-style-type: none"> <li>* Needs to be corrected or accommodated appropriately, otherwise difficult to control pelvis</li> </ul>	Lumbar spine:  Thoracic spine:  Cervical spine:	
	Factor	Guidance	Assessment Findings	Recommendations
6	Sitting Balance	This may give an idea of the amount of support required within the seating system	Independent:  Independent using hands to bear weight:  Ax1:  Ax2:	
7	Transfer Technique	Please indicate how the patient transfers, including with or without an aid e.g. standing hoist, Stedy Zimmer frame etc	Independent:  Ax1:  Ax2:  Hoist:	

	Factor	Guidance	Assessment Findings	Recommendations
8	Skin Inspection	Please complete a full skin inspection and indicate what type of cushion client requires	Skin intact: Existing pressure damage evident: Evidence of previous pressure damage: Moisture damage evident: Braden scale score:	

Additional Information, Recommendations, or Chairs Trialled

OT Signature:



# Basic Seating Assessment

Name:

Date:

Client ID:

1. Hip Width (cm)	
2. Hip to knee (popliteal crease) (cm)	
3. Back of knee (popliteal crease) to floor(cm)	
4. Height (cm)	
5. Weight (kg)	
6. Any additional measurements	

OT Signature: