FIREFLY

SEATING AND MOBILITY CLINIC SCREENER

To be completed by the referring OT/PT

Client First Name: **Client Last Name:**

Date of Birth: **EMHware #:**

Health Card #: **NIHB #:**

Informant completing the screener:

School/Daycare: **Date of Screener:** 2025-01-14

Preferred Contact Name: **Preferred Contact Phone:**

Please submit any previous OT/PT specialist assessment reports.

Medical Diagnosis

Does the child have a diagnosis that is affecting their mobility? ☐ Yes ☐ No

Child is diagnosed with the following (please specify):

Current/Past Services

My child is currently receiving or has been seen in the past by:

	Specialist and/or Clinic	**Date**	**Results**
☐ Augmentative & Alt. Specialist/Clinic			
☐ Behaviour Therapist			
☐ Hearing Specialist			
☐ Mental Health Clinician			
☐ Neurologist			
☐ Occupational Therapist			
☐ Orthopedist			
☐ Physiatrist			

☐ Physiotherapist			
☐ Seating Specialist			
☐ Service Coordinator			
☐ Speech Language Pathologist			
☐ Vision Specialist			
☐ Other (Please specify)			

Current Device Information

Which of the following mobility devices does the client presently use?

Manual wheelchair			
Make:	Model & Serial #:	Date received/age of device:	Who prescribed the device?
Cushion and back support information for manual wheelchair (if applicable)			
Make:	Model & Serial #:	Date received/Age of device:	Who prescribed the device?

How was the device funded?					
☐ ADP	☐ NIHB	☐ ASCD	☐ Jordan's Principal	☐ School	☐ Private Insurance

Power wheelchair			
Make:	Model & Serial #:	Date received/age of device:	Who prescribed the device?
Cushion and back support information for manual wheelchair (if applicable)			
Make:	Model & Serial #:	Date received/age of device:	Who prescribed the device?

How was the device funded?					
☐ ADP	☐ NIHB	☐ ACSD	☐ Jordan's Principle	☐ School	☐ Private Insurance

Pediatric Specialized Stroller			
Make:	Model & Serial #:	Date received/age of device:	Who prescribed the device?

How was the device funded?					
☐ ADP	☐ NIHB	☐ ACSD	☐ Jordan's Principle	☐ School	☐ Private Insurance

Stander			
Make:	Model & Serial #:	Date received/age of device:	Who prescribed the device?

How was the device funded?					
☐ ADP	☐ NIHB	☐ ACSD	☐ Jordan's Principle	☐ School	☐ Private Insurance

Walker / Gait Trainer			
Make:	Model & Serial #:	Date received/age of device:	Who prescribed the device?

How was the device funded?					
☐ ADP	☐ NIHB	☐ ACSD	☐ Jordan's Principle	☐ School	☐ Private Insurance

What do you and the client <u>like</u> about their current device and <u>do not</u> want changed?

What do you and the client <u>not like</u> about their current device and <u>want</u> changed?

What are you hoping to achieve from the Seating Clinic?

Additional information:

If this is a referral from a third-party provider and the child is not yet a client of FIREFLY, please complete a General Referral Form (**click here**) and fax all documentation to FIREFLY's Centralized Intake at 1-866-470-1783 or by email to **intake@fireflynwca**.