Thames Valley Children's Centre

Seating and Mobility Referral Form

Name: _____ **Date of Birth:** _____

Diagnosis: _____ **Date:** _____

**Eligibility for funding of equipment through the Assistive Devices Program of Ontario (ADP) will be discussed with families during a seating and mobility assessment. If you have questions regarding client eligibility please contact a SAMS therapist to discuss.*

Is the individual currently using a mobility device? Yes ☐ No ☐
Please specify

Please check off what you and the family hope to achieve through a seating and mobility assessment or consultation

Seating and Mobility Assessment

- ☐ Improved seated posture for mobility
- ☐ Independent mobility (Manual/Power wheelchair)
- ☐ Dependent mobility (Stroller/Manual wheelchair)
- ☐ Mobility for Distance
- ☐ Other

Alternative Positioning Seating Consultation

(Community therapist will direct course of action)

- ☐ Improved Feeding Posture
- ☐ An alternative position for play
- ☐ School chair
- ☐ Other

Other Pertinent Information:

Please complete this form and return to SAMS.

Name: Agency:

Signature: Address:

Title: Contact Number:

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