

OCTC SEATING AND MOBILITY SERVICE REFERRAL FORM

The **Seating and Mobility Service at OCTC** serves children and youth who require support in sitting and/or assistance with moving around their environment. Our team works with you and your child, your community therapist, and a vendor of your choice to provide comfortable, functional equipment to meet your child's postural and mobility needs. Equipment may include specialized strollers and car seats, manual and power wheelchairs, and custom-made cushions. Our team assists families with the funding process for any equipment that is recommended.

Child's name:	Date o	of Birth:/
Address:	City:	Postal Code:
Health Card:	Version Code	Expiry Date:
Parent/Guardian(s):	Re	lationship:
My preferred method of communic	cation:	
☐ Phone: ()	Phone: ()
☐ E-mail:		
School:		Permission to contact Yes No
Therapists or other community ag	encies:	
		_Permission to contact Yes No
	ting posture, comfort and/or u	ise of the current equipment (pleas
check all that apply): Recent medical changes Fatigue Safety issues Current equipment does not m Current equipment is too small My child currently does not have	ve any equipment	Skin changes/pressure soresTransportation issues
My signaturo indicatos my conso	nt to proceed with the Seating on	ad Mobility assessment for my childs
My signature indicates my conse Parent/guardian signature:	•	nd Mobility assessment for my child:

Once you have returned the completed form, you will be contacted by the Seating and Mobility Service to discuss the next steps in the process.

Tel: 613-737-0871 x 4425, Fax: 613-738-4841

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