Ottawa Children's Treatment Centre
Centre de traitement pour enfants d'Ottawa
Founded in 1951 Fondé en 1951

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.*

Please check all that apply:

☐ This is my child's first time accessing this service
☐ My child has accessed this service in the past
☐ My child may need a specialized stroller or wheelchair
☐ My child may need a specialized carseat
☐ My child's Occupational or Physical Therapist recommended this service

Child's name: _____ Date of Birth: _____/_____/_____
D M Y

Address: _____City:_____ Postal Code: _____

Health Card: _____Version Code _____ Expiry Date: _____

Parent/Guardian(s): _____ Relationship: _____

My preferred method of communication:

☐ Phone: ( ) _____ ☐ Phone: ( ) _____

☐ E-mail:_____

School: _____ Permission to contact ☐ Yes ☐ No

Therapists or other community agencies: _____

_____Permission to contact ☐ Yes ☐ No

My concerns for my child's sitting posture, comfort and/or use of the current equipment (please check all that apply):

☐ Recent medical changes
☐ Recent/upcoming surgery
☐ Recent weight gain/loss
☐ Fatigue
☐ Pain
☐ Skin changes/pressure sores
☐ Safety issues
☐ Broken equipment
☐ Transportation issues
☐ Current equipment does not meet daily needs at home/school/community
☐ Current equipment is too small/ too large/ poor fit or support
☐ My child currently does not have any equipment

Comments: _____

_____

My signature indicates my consent to proceed with the Seating and Mobility assessment for my child:

Parent/guardian signature: _____ Date: _____

Parent/guardian name: _____

Please return this form to: Anne Lukey, Intake Services
Ottawa Children's Treatment Centre, 395 Smyth Road, Ottawa, ON K1H 8L2
Tel: 613-737-0871 x 4425, Fax: 613-738-4841

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.