

Section 2
Functional Assessment – page 1/3

A. Weightbearing/ Transfers and Lifts	
Walking:	<input type="checkbox"/> Not at all <input type="checkbox"/> Inside home <input type="checkbox"/> In community Distance/ terrain/ aids used:
Transfers:	(Describe method/ equipment / assistance/ frequency/ optimal seat to floor height)
Lifts:	(Describe method/ equipment / assistance/ frequency)

B. Wheelchair Mobility			
<input type="checkbox"/> Manual:	<input type="checkbox"/> (L) arm propulsion <input type="checkbox"/> (L) foot propulsion	<input type="checkbox"/> (R) arm propulsion <input type="checkbox"/> (R) foot propulsion	<input type="checkbox"/> Dependent for mobility
<input type="checkbox"/> Stroller:			
<input type="checkbox"/> Power mobility: Drive method:	<input type="checkbox"/> Power wheelchair (eg. Control site; R or L handed)	<input type="checkbox"/> Scooter (eg. Style of control on tiller)	
Comments:	(eg. Terrain; distance; endurance)		

C. Self Care	
Method of eating: Comments/ risk factors:	<input type="checkbox"/> Independent <input type="checkbox"/> Assisted <input type="checkbox"/> Dependent <input type="checkbox"/> Tube Feed
Bowel and bladder management:	<input type="checkbox"/> Continent Incontinent of: <input type="checkbox"/> Bladder <input type="checkbox"/> Bowel <input type="checkbox"/> Indwelling catheter <input type="checkbox"/> Condom Drainage <input type="checkbox"/> Intermittent Catheterization <input type="checkbox"/> Incontinence Products: Frequency/ Schedule:
Other ADL/ IADL: Methods/ Aids / Assistance used:	(eg. Dressing/ housekeeping/ meal preparation/ banking/ collecting mail/ laundry)

Relevant Implications

Section 2: Functional Assessment continued – page 2/3

D. Work/ School and Leisure	
School/ Work:	
Leisure activities/ interests:	

E. Perceptual and Cognitive Status	
Vision:	<input type="checkbox"/> Functional / glasses <input type="checkbox"/> Impaired <input type="checkbox"/> Blind <input type="checkbox"/> L / R neglect <input type="checkbox"/> L / R visual field loss Comments:
Hearing:	<input type="checkbox"/> Functional/ hearing aids: L / R <input type="checkbox"/> Impaired Comments:
Functional cognitive ability: (eg. judgment/ insight/ attention/ concentration/ memory/ learning/ impulse control/ problem solving/ motor planning)	<input type="checkbox"/> No apparent cognitive difficulties. Cognitive Screen used: <input type="checkbox"/> Y <input type="checkbox"/> N Score: Name of screening tool:
Cognitive/ Perceptual testing:	Further cognitive/ perceptual testing necessary: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Tests completed: <input type="checkbox"/> Tests to be completed: <input type="checkbox"/> North Shore Health Region Power Mobility Assessment in the Community Tool <input type="checkbox"/> VIHA Power Mobility Toolkit <input type="checkbox"/> Other:
	Comments:

F. Communication			
Method/ Aids used:	<input type="checkbox"/> Verbal	<input type="checkbox"/> Non Verbal	<input type="checkbox"/> Augmentative Communication Device:
Ability to direct care:			

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G. Environment

1. Home Accessibility

Entrances:	(eg. Building/ suite)
Stairs/ Ramps:	(eg. # of stairs/ location/ landings/ angle and width of ramp)
Elevator:	(eg. size/ access/ controls)
Flooring:	(eg. Carpet/ laminate/ thresholds)
Table heights:	
Access to: (consider narrowest door, corners, turning radius, transfer heights, etc.)	Kitchen: Bedroom: Bathroom: Toilet: Other:
Charging area:	
Community accessibility:	(school/ work/ outdoor terrain/ sidewalks/ curb/ elevators, etc.)

2. Transport

Method of transport:	<input type="checkbox"/> Handidart	<input type="checkbox"/> Bus	<input type="checkbox"/> Taxi
	<input type="checkbox"/> Tie down required?		
	<input type="checkbox"/> Car:	<input type="checkbox"/> 2 Door	<input type="checkbox"/> 4 Door
	<input type="checkbox"/> Car seat required?	<input type="checkbox"/> Hatchback	<input type="checkbox"/> SUV
	<input type="checkbox"/> Van: If driving self: <input type="checkbox"/> Driving in w/c <input type="checkbox"/> Transfer to seat	Overall client height in w/c: _____	Minimum clearance height: _____
Method of loading:	<input type="checkbox"/> Manually assisted (who, where):		
	<input type="checkbox"/> Power lifts (specify location):		
	<input type="checkbox"/> Ramp:	<input type="checkbox"/> Other:	

Relevant Implications
