WHEELCHAIR SCREEN

Pt Name: ____________________________ Room Number __________________________

Reason for referral: __________________________________________________________

**Position in wheelchair:**
Abnormal posture in wheelchair: _______________________________________________

Cushion in wheelchair appropriate for skin condition: _______________________________

Recent change in skin condition: ________________________________________________

Pt able to self-propel the wheelchair: ___________________________________________

Functional change in status related to positioning: ________________________________

Functional change in status requiring change in wheelchair: _______________________

Pain related to positioning: ____________________________________________________

Loss of ROM: _________________________________________________________________

Recent fall from wheelchair: ___________________________________________________

Therapist Name________________________ Date________________