YOUR LOGO
(optional)

CLINIC / PRACTITIONER NAME

Form OT-WC-01

Address · phone · license #

Wheelchair & Seating Assessment

Seated measurements, posture, and equipment recommendations for wheelchair provision.

CLIENT INFORMATION

Client name

Date of birth

Medical record # / ID

Date of assessment

Diagnosis / prognosis

Funding source

Height

Weight

Primary environment

CURRENT EQUIPMENT

Current mobility device

Age of device

Reported problems with current equipment

MEASUREMENT	RIGHT	LEFT	NOTES

Suggested: hip width · seat depth · lower leg length · back height · shoulder height · elbow height · foot length · chest width

POSTURE, SKIN & SENSATION

- ☐ Pelvic obliquity
- ☐ Pelvic rotation
- ☐ Windswept lower limbs
- ☐ History of pressure injury
- ☐ Posterior pelvic tilt
- ☐ Scoliosis
- ☐ Limited hip / knee ROM
- ☐ Current skin breakdown
- ☐ Anterior pelvic tilt
- ☐ Kyphosis
- ☐ Impaired sensation
- ☐ Independent pressure relief

Functional status — transfers, propulsion, endurance, and transport

ITEM	SPECIFICATION	MEDICAL JUSTIFICATION

ADDITIONAL NOTES

Continuation, observations, or notes

SIGNATURES

This assessment reflects the client's measured needs and supports the equipment recommended above.

Therapist signature (OTR/L)

Date

Supplier / ATP signature

Date