Adult Power Tilt-in-Space Request

Alberta Aids to Daily Living (AADL) Program

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Mail this form and 1250 Authorization form to: AADL, Telus House, 13th Floor, 10020 100 Street NW, Edmonton, AB T5J 0N3.

1. Complete the form in the spaces provided, grading the client’s problem on a 1-5 range (5 being the most severe, and 1 indicating that the factor is not a problem).
2. Add clinical documentation to support the grading score.

Authorizer Name ___________________________ Authorizer No. ________________

Client Name ___________________________ PHN ________________

Diagnosis ________________________________

☐ Yes ☐ No   Is client currently using a power tilt system?
☐ Yes ☐ No   Is client currently using a power tilt/recline system?
☐ Yes ☐ No   Is client currently using power elevating leg rests?

Describe why current base is no longer appropriate: ________________________________

______________________________________________

<table>
<thead>
<tr>
<th>GRADING</th>
<th>PHYSICAL FACTORS INDICATING NEED FOR TILT-IN-SPACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>Inability to maintain upright posture; describe: ________________________________</td>
</tr>
<tr>
<td></td>
<td>Degree of tilt needed to maintain trunk: ________</td>
</tr>
<tr>
<td>1 2 3 4 5</td>
<td>Inability to maintain upright head position; describe: ________________________________</td>
</tr>
<tr>
<td></td>
<td>Degree of tilt needed to maintain head position: ________</td>
</tr>
<tr>
<td>1 2 3 4 5</td>
<td>Inability to weight shift; describe: ________________________________</td>
</tr>
<tr>
<td>1 2 3 4 5</td>
<td>Reduced sitting tolerance due to fatigue; describe: ________________________________</td>
</tr>
</tbody>
</table>
1 2 3 4 5  Compromised respiratory system; describe: ____________________________

1 2 3 4 5  Pressure relief; describe history of skin problems: ______________________

1 2 3 4 5  Impaired sensation; describe: ____________________________

1 2 3 4 5  Improved ability to do ADLs; describe: ____________________________

1 2 3 4 5  Pain relief; describe problem: ____________________________

1 2 3 4 5  Feeding/swallowing concerns; describe problem: ______________________

1 2 3 4 5  Circulatory problems; describe: ____________________________

☐ Yes  ☐ No  On trial, did client operate power tilt independently?

☐ Yes  ☐ No  Function and Endurance: AADL expects that tilt-in-space will allow client to be in mobility base for a minimum of 8 consecutive hours. Sitting tolerance increased to 8 hours by tilt trial? If “No”, then how long? __________

☐ Yes  ☐ No  Postural Tone: Extensor pattern prevents sitting, and is reduced/broken by tilt-in space.

**PHYSICAL FACTORS INDICATING NEED FOR POWER RECLINE**

Does client need static or dynamic recline?  ☐ Static  ☐ Dynamic

If static recline, describe why the hip angle needs to be opened: ____________________________

________________________________________________________________________

If dynamic recline, describe why the hip angle needs to be changed frequently throughout the day:

________________________________________________________________________

**PLEASE NOTE:** Power elevating leg rests and foot boards are the financial responsibility of the Client.