

Manual W/Chair – Trial Request

Please complete and fax to Motion Wheelchairs on 03 9583 6216

Client Name: _____

Client Address: _____

Client Email: _____

Parent/Carer Name: _____ Client Contact Phone: _____

Therapist: _____ Therapist Organisation: _____

Therapist Phone: _____ Therapist Fax: _____

Therapist Email: _____

Wheelchair Model (preferred): _____

Requested Appointment Venue: _____



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e contact@motionwheelchairs.com

w www.motionwheelchairs.com

Client Details:

Appt Date/Time: _____

Condition of Disability: _____

Clinical Requirements: _____

Client Age: _____ Date of Birth: _____ Client Weight: _____

FUNDING - SWEP TAC Claim No: _____ NDIA No: _____ Plan Dates: ___/___/___ to ___/___/___

Client Measurements: Please use the diagram as a guide.

A. Top of Shoulders: _____	F. Elbow to Hand: _____	
B. Chest Depth: _____	G. Seat Pan to Elbow: _____	
C. Chest Width: _____	H. Hip Width: _____	
D. Seat Depth: _____	I. Knee to Foot: _____	
E. Top of Head: _____		

Features Required: Please Tick:

<input type="checkbox"/> Pressure Care <i>Please specify preferred type:</i> <hr/> Tilt in Space – Rigid Chair <input type="checkbox"/> 55 degree range <input type="checkbox"/> 40 degree range Suggest... <hr/> <input type="checkbox"/> Lightweight Folding Wheelchair Suggest... <hr/> <input type="checkbox"/> Seat Cushion Suggest... <input type="checkbox"/> Backrest Suggest... <input type="checkbox"/> Moulded Backrest <input type="checkbox"/> Backrest Recline <input type="checkbox"/> Fold forward for Transport	<input type="checkbox"/> Swing Away Leg Rest <input type="checkbox"/> Adjustable Angle Footrest <input type="checkbox"/> Elevating Leg Rest <input type="checkbox"/> Ankle Huggers <input type="checkbox"/> Taddy Cups with Pelvi-loc straps <input type="checkbox"/> Headrest <input type="checkbox"/> Removable Armrest <input type="checkbox"/> Flip Up Armrest <input type="checkbox"/> Lateral Thoracic Support Swing away <input type="checkbox"/> Fixed <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> Hip Support Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> Adduction Support Gel button pads <input type="checkbox"/> Foam Padded <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/>	<input type="checkbox"/> Abduction Pommel Lift out <input type="checkbox"/> Flip down <input type="checkbox"/> <input type="checkbox"/> Lap Belt style Pelvi-Loc <input type="checkbox"/> 4 Point <input type="checkbox"/> 2 Point <input type="checkbox"/> <input type="checkbox"/> Harness – Style Suggest... <input type="checkbox"/> Calf strap <input type="checkbox"/> Tray <input type="checkbox"/> Heavy Duty Use <input type="checkbox"/> Growth in Frame/Seating <input type="checkbox"/> Transport Tie Downs <input type="checkbox"/> Outdoor Mobility/Access <input type="checkbox"/> Other (please specify) <input type="checkbox"/> Low Seat Height / standing transfers <input type="checkbox"/> Self Propelling <input type="checkbox"/> Attendant Propelled transit style
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