Power - Trial Chair Request

Please complete and fax to Motion Wheelchairs on 03 9583 6216

34 Shearson Crescent Mentone Vic 3194
t + 61 3 9584 9777
f +61 3 9583 6216
e contact@motionwheelchairs.com
w www.motionwheelchairs.com

Client Name:_____

Client Address:_____

Client Email: _____

Parent/Carer Name:_____**Client Contact Phone:**_____

Therapist:_____**Therapist Organisation:**_____

Therapist Phone:_____**Therapist Fax:**_____

Therapist Address:_____

Therapist Email: _____

Requested Appointment Venue:_____

Wheelchair Model *(if known):* _____

Client Details:

Appt Date/Time: _____

Condition of Client: _____

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.*

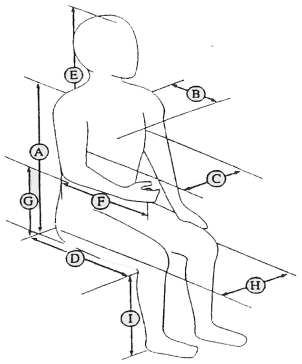
A. Top of Shoulders:_____ **F. Elbow to Hand:** _____

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:*

☐ Pressure Care
*Please specify type:*_____
☐ Stability
☐ Positioning
☐ Lateral Support
☐ Headrest
☐ Harness
☐ Transport Tie Downs
☐ Flip Up Armrest
☐ Removable Armrest
☐ Outdoor Mobility/Access

☐ Low Seat Height
☐ Growth in Frame/Seating
☐ Heavy Duty Use
☐ Tilt in Space
☐ Recline
☐ Seat Lift
☐ Elevating Leg rest
☐ Adjustable Angle Footrest
☐ Fold Down for Transport
☐ Other (please specify)

_____

Joystick/ Controllers:
☐ Right
☐ Left
☐ Attendant
☐ Head/Chin
☐ Other _____
☐ Client driving ability
Poor/average/good

Other Requirements: *Please provide any additional information here.*

_____

_____