|  |  |  |
| --- | --- | --- |
| PLEASE AFFIX PATIENT ID LABEL OR BLOCK PRINT DATA | | |
| **FAMILY NAME:** | **UMRN:** | |
| **GIVEN NAME:** | **DOB:** | **GENDER:** |
| **ADDRESS** | **POSTCODE** | |
| **ALTERNATIVE CONTACT DETAILS:** | **TELEPHONE NUMBER:** | |

**Rehabilitation Engineering Clinic**

**Health Technology Management Unit - EMHS**

Level 2 - State Rehabilitation Centre, FSH

20 Fiona wood Road, MURDOCH WA 6150

**T: 08 6152 7047**

**Email: FSH.Referrals@health.wa.gov.au**

**Funding**:  Public  MVIT  W/Comp  NDIS  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_

**POWERED WHEELCHAIR REQUEST FORM**

Please complete and email to: mailto: **FSH.Referrals@health.wa.gov.au**

|  |  |
| --- | --- |
| **Ward:** | **Doctor:** |
| **Diagnosis:** | |

**LOAN PERIOD**: 3 Months  6 Months  12 Months  Patient/Agency Funded

**WHEELCHAIR REQUIREMENTS** (tick all appropriate)

Seat Width: 40cm  43cm  46cm  49cm  Other (specify):\_\_\_\_\_\_\_\_\_\_

Seat Depth: 40cm  43cm  46cm  49cm  Other (specify):\_\_\_\_\_\_\_\_\_\_

Knee to Heel Measurements: \_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Controller: | Left Hand |  | Right Hand |  | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Joystick Mount | Inline |  | Swing Away |  | Speed (km/h)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Switch/Button | On/off |  | Mode |  |  |  |
| Power Actuators | Tilt |  | Recline |  |  |  |
| Pelvic Belt: | Standard |  | Tamper Proof |  |  |  |
| Armrest Style | Flip Up |  | Single/double post |  |  |  |
| Arm Trough: | Left |  | Right |  |  |  |
| Elevating Leg Support: | Left |  | Right |  |  |  |
| Stump Support: | Left |  | Right |  |  |  |
| Head Support: | Standard |  | Other |  |  |  |

**Braden Scale:** \_\_\_\_\_\_\_\_\_\_\_\_ **Weight:** \_\_\_\_\_\_\_\_ **Cushion Type**:  Ward 2  Flat Foam

**If a clinic appointment is required, contact REC Clinician.**

**Additional comments** (e.g.Type of transfer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| \***Doctor’s Authorisation for fitting of pelvic strap:** | | | | |
| Doctor’s Signature: | | Print Name: | | |
| Referral Number for pelvic belt: | | | | |
| Therapist Signature: | | | Print Name: | |
| Date: | | | Phone/Pager: | |
| **REC STAFF ONLY** | Date: | | Device Number: |  |
| Referral Number: | | | Technician: |  |
| Cushion Number: | | |  | |

Terminology complies with ISO 7176-26.