|  |
| --- |
| 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |
| --- |
| \***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.