

Sunrise Medical – Referral Form

Date:	
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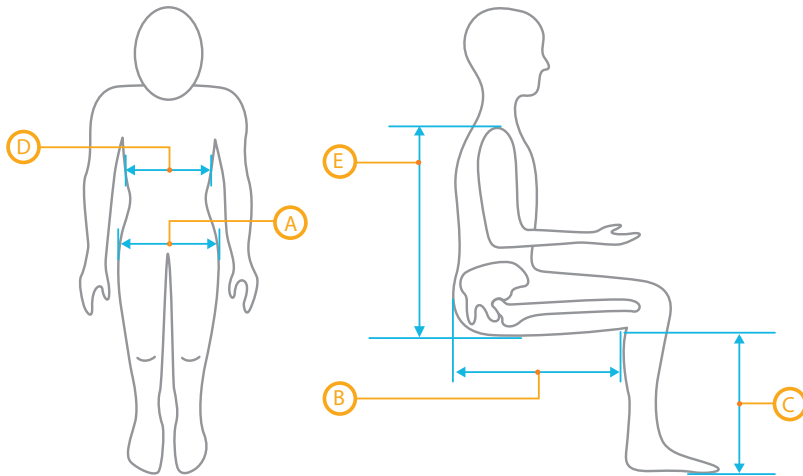
Therapist Details:				
Name:				
Phone:		Email:		
Reason for referral:	<input type="checkbox"/> Postural assessment	<input type="checkbox"/> Review of current wheelchair/seating	<input type="checkbox"/> Equipment trial	<input type="checkbox"/> "The Lot" Assessment, review and trial
Preferred Dealer:		Contact:		

Client Details:			
Name:		Age:	
Contact number:		Approx. Weight:	
		Approx. Height:	
Primary Diagnosis:			
Cognition:			
Pressure history:			
Continence:			
Medical/behavior precautions:			
Additional information:			
Support coordinator:		Email/phone:	
Funding:			

Client's current function:	
Mobility:	MWC: <input type="checkbox"/> Independent <input type="checkbox"/> Dependent PWC: <input type="checkbox"/> Independent <input type="checkbox"/> Dependent
Transfers:	<input type="checkbox"/> Independent <input type="checkbox"/> Minimal assistance <input type="checkbox"/> Maximal assistance <input type="checkbox"/> Hoist
Transport:	<input type="checkbox"/> Drives <input type="checkbox"/> Passenger in car <input type="checkbox"/> Public transport <input type="checkbox"/> Accessible vehicle

Client's current equipment:	
Wheelchair (type and setup):	
Cushion:	
Backrest:	
Headrest:	
Accessories:	
Serial # (if Quickie chair):	

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Body Measurements:

A. HIP WIDTH: _____

B. SITTING DEPTH:

R: _____ L: _____

C. LOWER LEG LENGTH:

WITH SHOES: YES ___ NO: ___

D. CHEST WIDTH: _____

E. SHOULDER HEIGHT:

R: _____ L: _____

Problem List:

- 1.
- 2.
- 3.

Visit Goals:

- 1.
- 2.
- 3.

Equipment hoping to trial:
Pictures of client in current wheelchair:
(Tick when attached)

- Lateral view
- Front view
- Rear view
- Top down view