AC MOBILITY

TRIAL PREASSESSMENT FORM

Therapist details **Date completed:**

Name: ☐ OT ☐ PT ☐ SP ☐ Other

Organisation / Company:

Working days: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Email:

Contact number:

Office address:

Client details

Name:

Age or DOB:

Address:

Access to home
(if requesting a home trial): ☐ Flat / level ☐ Small threshold ☐ Steps ☐ Parking for van

Parent / Carer's name:

Contact number:

Email address:

Client Height:

Client Weight:

Diagnosis:

GMFCS level (if relevant): ☐ I ☐ II ☐ III ☐ IV ☐ V

Other relevant medical information:

Vision: ☐ No abnormality ☐ Glasses ☐ Vision impaired

Hearing: ☐ No abnormality ☐ Hearing impaired

Feeding: ☐ Oral ☐ PEG feeds ☐ Both

Speech: ☐ Verbal ☐ Non-verbal ☐ AAC

Orthoses: ☐ Yes ☐ No

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Does the client experience pain? If so, please provide details:

Where will the equipment be used?

- ☐ Home
- ☐ School
- ☐ Work
- ☐ Inside/outside
- ☐ Inside only
- ☐ Outside only
- ☐ Beach
- ☐ Rural / remote

Other

Items requested for trial & sizing:

Any sensitive information the therapist needs to be aware of prior to trial:

Equipment you would like to trial or receive more information on:

- ☐ Strollers
- ☐ Manual wheelchairs
- ☐ Power mobility
- ☐ Standers
- ☐ Walkers/gait trainers
- ☐ Postural support
- ☐ Floor sitters
- ☐ Alternative indoor seating
- ☐ Car seats
- ☐ Toileting
- ☐ Shower / bath
- ☐ Beds/sleep
- ☐ Desks
- ☐ Exercise and recreation
- ☐ Other
- ☐ Please advise:

Measurement Details

Seating:	Back Height (cm)		Seat Depth (cm)	
	Seat - Axilla (cm)		Hip Width (cm)	
	Lower Leg (cm)		Chest Width (cm)	
Standing/ Walking:	Heel - Axilla (cm)		Heel - ASIS (cm)	
	Heel - Knee (cm)		Heel to elbow(cm)	
	Inner Leg (cm)		Chest Width (cm)	

Preferred time/dates for trial:

Is therapist familiar with the equipment: ☐ Yes ☐ No

Occupational Therapist required: ☐ Yes ☐ No

Best method of communicating with client: ☐ Phone ☐ Text ☐ Email ☐ Other

Interpreter required: ☐ Yes ☐ No Language