|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Enable_RGB | | | **ENAO801** | **WHEELCHAIR & SEATING OUTREACH SERVICE**  **outreach@enable.co.nz0800 171 995** | | | |
| **REFERRAL FOR AN APPOINTMENT** | | | | | | | |
| Date of Referral | | /    / | | | Preferred Time | |  |
| Date of Next Clinic | | /    / | | | Impossible Times | |  |
| Address for Clinic Appoinment: | | | | | | | |
| Technician required: yes  no | | | | | Client meets MOH eligibility criteria: yes  no | | |
| **CLIENT DETAILS** | | | | | **EMS ASSESSOR DETAILS** | | |
| NHI |  | | | | Name |  | |
| Name |  | | | | AEA No: |  | |
| Date of Birth | /  / | | | | Email Address |  | |
| Telephone |  | | | | Telephone | (     ) | |
| Gender | Male  Female | | | | Mobile | (     ) | |
| Ethnicity |  | | | | WMPML1  WMPML2  WMPM Custom  WMPM Lying | | |
| Diagnosis |  | | | |  | | |

Please provide information on the following –

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CONTEXT –** description of the social and environmental situation.  Please include information such as where the person lives, where the person works / attends school, how they access transport, any limitations around access, environmental challenges, any liaison with a specialist vehicle assessor or any liaison with TalkLink. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| ***The equipment is essential for:*** | | | | | | | **Resides** | | | | | | | | | |
| Mobility in the home | | Remaining in the home | | | | | Own home | | | | | | | | | |
| Fulltime Education | | Main Carer | | | | | Residential Care Over 65 | | | | | | | | | |
| Fulltime Employment | | Vocational Training | | | | | Residential Care Under 65 | | | | | | | | | |
| Communication | | Voluntary Work | | | | | Lives Alone | | | | | | | | | |
| **FUNCTIONAL LIMITATIONS –** description of the relevant disability and limitations experienced by the person. Please include information such as how the person currently mobilises, how they transfer in/out of their chair, any specific challenges faced by the person. | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **LIST CURRENT WHEELCHAIR AND SEATING SYSTEM AND CHALLENGES FACED WITH THESE** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **GOALS OF SEATING AND MOBILITY** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **ASSESSMENT FINDINGS** | | | | | | | | | | | | | | | |
| **Measurement** | | | | | | | | | | | | | | | |
| **Note:** These measurements are essential    **D** | | | **A** |  | | | | **C (L)** | | | | |  | | |
|  | | | **B (L)** |  | | | | **C (R)** | | | | |  | | |
|  | | | **B (R)** |  | | | | **D** | | | | |  | | |
|  | | | **Physical Findings:** | | | | | | | | | | | | |
|  | | | Pelvic Tilt | | Neutral | | | | | | | | | | |
|  | | |  | | Posterior | | | | | | | fixed | | flexible | |
|  | | |  | | Anterior | | | | | | | fixed | | flexible | |
|  | | | Obliquity down | | left | | | | | right | | fixed | | flexible | |
|  | | | Rotation towards | | left | | | | | right | | fixed | | flexible | |
|  | | | Hip flexion ROM | | left | | | | | | | right | | | |
|  | | | Knee flexion ROM | | left | | | | | | | right | | | |
|  | | | Kyphosis | | | | | | | | | fixed | | flexible | |
|  | | | Lordosis | | | | | | | | | fixed | | flexible | |
|  | | | Scolosis Concave to | | | left | | | right | | | fixed | | flexible | |
| Essential seat to floor height |  | | Does this include a cushion? | | | | | | | | YES  NO | | | | |
| Additional Assessment Information: | | | | | | | | | | | | | | | |
| Please paste any photos into this section: | | | | | | | | | | | | | | | |