# TRIAL EQUIPMENT
# REQUEST FORM

Date:

**Prescriber Details**

Name: Position:

Best Phone: Email:

**Client Details**

Client Name: D.O.B: Height:

Approx. Weight: Male ☐ Female ☐

Address:

Best Phone: Alternate Contact:

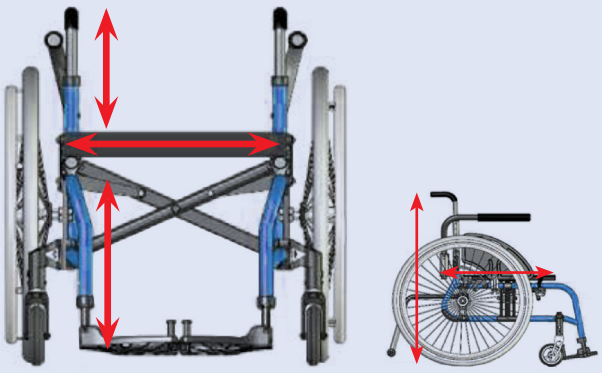
Support Co-Ordinator: Email/Phone:

Funding Source: Claim Number:

Intended environmental use and prefer method of transport:

Client Condition (including Cognitive, Physical ability and any infectious diseases):

**Current Equipment**



Seat Width: _____

Seat Depth: _____

Front Seat Height: _____

Rear Seat Height: _____

Backrest Height: _____

Push Handle Height (If applicable): _____

Seat Upholstery to Foot Plate: _____

Brand: _____

Model: _____

Notes:

Please turn over page >

58-60 Star Crescent
Hallam Vic 3803
P: 03 9796 3399
F: 03 9796 3313
E: admin@lindsrehab.com.au
W: www.lindsrehab.com.au

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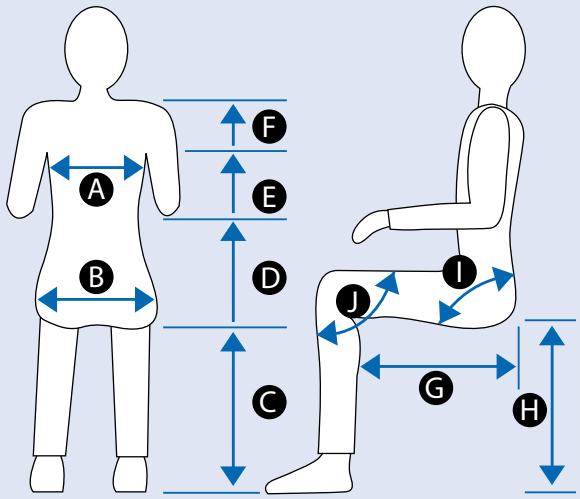
LINDS® REHABILITATION EQUIPMENT

**Anthropometric Measurements**




**A** Chest Width: _____ Shoulder width: _____

**B** Hip Width: _____

**C** Lower Leg Length: _____

**D** Armrest Height: _____

**E** Thoracic Height: _____

**F** Shoulder Height: _____

**G** Upper Leg Length: _____

**H** Seat to Floor – Front: _____ Rear: _____

**I** Approximate resting Hip Angle: _____

**J** Lower Leg Angle: _____

*Note: take widest measurement if asymmetrical*

MAT Evaluation Outcomes:

Trial Equipment Required:

Manual Wheelchair: ☐ Tilt in space: ☐

Power Wheelchair: ☐ Shower commode and hoist: ☐

Right ☐ or Left ☐ hand control

Notes:

Thank you for using our form, please email through to admin@lindsrehab.com.au and you will receive a call from one of our consultant's to confirm an appointment time with you.

All information included above will be kept in accordance with Linds Rehabilitation Equipment privacy policies.

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