Client Details Form

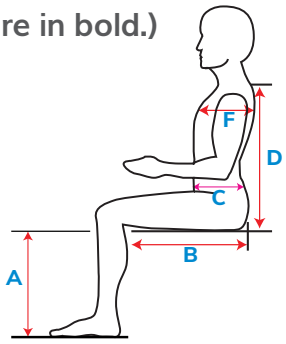
Therapist Details		Client Details	
Name:		Name	
Organisation		DOB	Male ☐ Female ☐
PO Box		Carer/Parent	
Suburb		Address	
City			
Ph		Ph	
Email		Email	
Mobile		Funding Body	

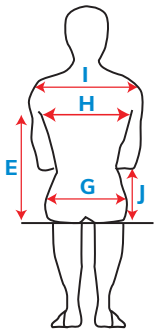
CLIENT MEASUREMENTS (Critical dimensions are in bold.)

Dated___/___/___

Medical Condition: _____

Approx. Weight:_____





Sitting:

A) **Lower Leg** (L) _____mm
(R) _____mm

B) **Upper Leg Length** (L) _____mm
(R) _____mm

C) Lower Trunk Depth _____mm

D) **Shoulder Height** _____mm

E) Axilla Height _____mm

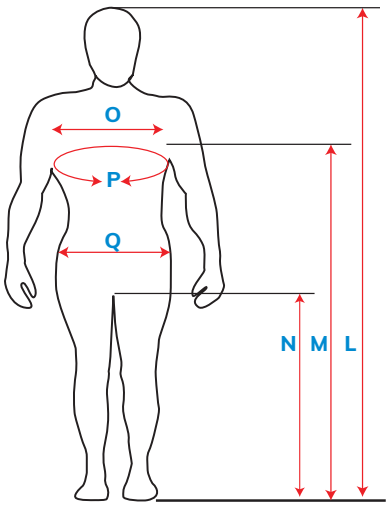
F) Chest Depth _____mm

G) **Hip Width** _____mm

H) Chest Width _____mm

I) Shoulder Width _____mm

J) Armrest Height _____mm



Standing: (can be measured lying down)

L) Total Height _____mm

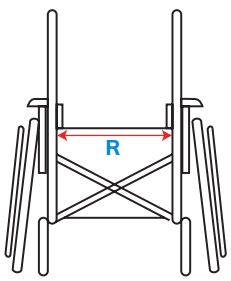
M) Axilla Height _____mm

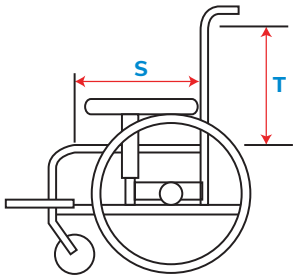
N) Inner Leg Length _____mm

O) Chest Width _____mm

P) Chest Circumference _____mm

Q) Hip Width _____mm





Wheelchair Measurements(if applicable)

R) **Seat Width** _____mm

S) **Seat Depth** _____mm

T) **Backrest Height** _____mm

All personal records collected will be handled in accordance with ARE's Privacy Policy which can be viewed on our website.

Select Wheelchair Requirements

Manual

- ☐ Self-Propelling
- ☐ Transit (pushed by carer)
- ☐ Light weight
- ☐ Tilt in space

Powered

Client Control:

- ☐ Right Hand
- ☐ Left Hand

Attendant Control:

- ☐ Rear

Armrests

- ☐ Standard
- ☐ Gutter: / Trough
- Left ☐
- Right ☐

Seating

- ☐ Laterals
- ☐ Pommel
- ☐ Pressure cushion:

Size:_____

Type:_____

Leg Rest Hanger

- ☐ Standard
- ☐ Stump Support:
  - Left ☐
  - Right ☐
- ☐ Elevating Leg rests:
  - Left ☐
  - Right ☐

Positioning

- ☐ Seat Belt
- ☐ Shoulder Straps
- ☐ Pelvic Belt

Other

- ☐ Tie down loops/Transport Approved

Prescriber Notes:

Access Rehabilitation Equipment
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