Power Wheelchair and Specialty Control Assessment Request

Client name:
Height of client:
Weight of client:
Seat base:
Seat width:
Lower Leg length:
Back Height:
Right or **Left** hand control (circle one, if applicable)

Referring Therapist: **Tentative Appointment Date:**

1. **Does the client have a funding source?**

2. **What type of mobility base is needed?**
   - ☐ Power rear wheel drive base
   - ☐ Power mid wheel drive base
   - ☐ Other:

3. **What drive controls are required on the trial PWC?**
   - ☐ Proportional Head Control (RIM)
   - ☐ Full Sip and Puff
   - ☐ Standard joystick with built-in display
   - ☐ Compact joystick with Separate display
   - ☐ Digital Head Controls *(ASL/Switch-It Head Array)*
   - ☐ Other:

4. **What seating components are needed on the trial PWC?**
   - ☐ Cushion Type: Size:
   - ☐ Backrest Type: Size:

5. **What other accessories are required on the trial PWC?**
   - ☐ Type of legrests *(centre mount, 70 degrees)*
   - ☐ Type of armrests *(waterfall, flat pads, Daher or Ottobock, with/without swivel unit)*
   - ☐ Type of headrest *(standard, Stealth or Whitmeyer)*
   - ☐ Ventilator Mounting *(left or right)*
   - ☐ Other

6. **Is the client a "first-time" driver (i.e. first PWC)? If not, specify current mobility base and seating components.**