**DFC Equipment Program:** Adults

**Scooter Assessment Form**

**Complete eligibility screen before proceeding with this prescription**

| Name: |  | Sex: 🞏 M 🞏 F | DOB: |  |
| --- | --- | --- | --- | --- |
| Address: |  | Phone No: |  |
| Clinician: |  | Agency: |  |
| Scooter being considered: 🞏3W 🞏4W |  | Assessment Date: |  |
| People consulted: |  |
|  |


## MEDICAL HISTORY

| Diagnosis/onset: |  |
| --- | --- |
|  | 🞏 Stable 🞏 Deteriorating |
| Current medications: |  |
|  |
| Medical officer: |  | Ph: |  |

## SOCIAL HISTORY

| 🞏 Lives alone 🞏 Spouse 🞏 Other family 🞏 Friend 🞏 Other |  |
| --- | --- |
| Carer’s general health (if applicable) |  |
| Accommodation: 🞏 Home/unit 🞏 Retirement village 🞏 Hostel 🞏 Other |  |
| Ownership: 🞏 Owner 🞏 Rents 🞏 Housing SA 🞏 Other |  |
| Storage site & recharging arrangements: |  |
| *(For recharging the battery an extension cord of 3m can be used, but it must remain in the same building)* |
| Does client understand the recharging requirements? 🞏 Yes 🞏 No |  |
| Is the area lockable? 🞏 Yes 🞏 No |
| Intended use of scooter: 🞏 Home (internal) 🞏 Home (external) 🞏 Community 🞏 Shops 🞏 Work |
| 🞏 Other |  |
| Comments on local terrain and access to property: |  |
| Areas where scooter usage will need to be assessed:  |  |
|  |
| Estimated distance travelled per day: |  |
|  |
| Driver’s license held: 🞏 Never 🞏 Not Current 🞏 Current  |  |
| If client has stopped driving, why? |  |
|  |
| Transportation of scooter: 🞏 Car 🞏 Van 🞏 Bus 🞏 Taxi 🞏 Other  |  |
| Details: |  |

#### PHYSICAL EVALUATION

| Height: |  | Weight: |  | Pain: | 🞏 Present 🞏 Absent |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pressure Care - are there any issues? |  |
|  |
|  |
| Ambulation status (note if aid used): |  |
| Transfers: |  |
|  |
|  |
| Lower Limb function (ROM, strength, balance): |  |
| Balance/trunk control (static and dynamic): |  |
|  |
|  |
| Upper Limb Function (dexterity, coordination, strength, etc.): | 🞏 Right handed 🞏 Left handed  |
|  |
|  |
| Head/neck (note ROM): |  |
| Bladder management: 🞏 Independent 🞏 Assisted 🞏 Dependent |  |
| Bowel management: 🞏 Independent 🞏 Assisted 🞏 Dependent |  |
|  |
|  |
| Hearing: 🞏 Normal 🞏 Impaired 🞏 Deaf |  |
| Visual history/aids:  |  |
| Visual acuity/fields: 🞏 Normal 🞏 Impaired |  |
|  |
|  |
|  |

###### COGNITION and PERCEPTION

| Insight:  |  | Learning ability: |  |
| --- | --- | --- | --- |
| Impulsiveness/response time/safety awareness: |  |
|  |
| Planning/problem solving: |  |
|  |
|  |
|  |
| Attention/concentration/memory: |  |
|  |
|  |
| Is further assessment/referral to another discipline required? 🞏 Yes 🞏 No |  |
|  |
|  |
|  |

## SCOOTER HISTORY

| Type: |  | Period of use: |  |
| --- | --- | --- | --- |
| Specifications/condition/problems: |  |
|  |
|  |
|  |

## CLIENT GOALS and CONCERNS

| Period of Use: |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

## ADDITIONAL NOTES/SUMMARY

| Period of Use: |
| --- |
|  |
|  |
|  |
|  |
|  |

| Short Term Plan(s): |  |
| --- | --- |
|  |
| Scooter recommended for trial: |  |
| Date: |  | Location: |  |
| Has Medical Clearance been received from Doctor? 🞏 Yes 🞏 No |
|  |
| 🞏 Obtain further info |  |
|  |
|  |
|  |
|  |
| 🞏 Other: |  |
|  |  |
|  |  |
|  |  |

| Info given to client: | 🞏 DFC Equipment Fact Sheet | 🞏 ILC Information sheet |
| --- | --- | --- |

| **Clinician’s Name:** |  |  |  |
| --- | --- | --- | --- |
| **Clinician’s Signature:** |  | **Date:** |  |