**Children and Adults**

Car hoist and wheelchair carrier assessment form

| Client Name: | | |  | | | Sex: 🞏 M 🞏 F | | 🞏 Other |  | | DOB: | |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address: |  | | | | | | | Phone No: | |  | | | |
| Clinician: | |  | | | Division: | |  | | | Date: | |  | |
| People consulted: | | | |  | | | | | | | | | |

**MEDICAL HISTORY**

| Diagnosis/Prognosis: | | | |  | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | |
| Pain: | |  | | | | | | | | |
| Height: | | |  | | Weight: |  | | | |  |
| What type of wheelchair is to be carried in the carrier: | | | | | | |  | | | |
|  | | | | | | | | | |
| Will the client have a carer with them? 🞏 Yes 🞏 No | | | | | | | |  | | |
|  | | | | | | | | | |
| Is the carer able to assist the client at both ends of the trip? Yes No | | | | | | | | | | |
| Environments where carrier will need to be loaded/unloaded: | | | | | | | | |  | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |

**TRANSFERS/MOBILITY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Ambulation status: | |  | | |
| Transfer in/out of car: | |  | | |
|  | | | |
|  | | | |
| How does the client manage the wheelchair/scooter? | | | |  |
|  | | | |
| Carer needs in assisting client: | | |  | |
|  | | | |
|  | | | |

**CLIENT GOALS and CONCERNS**

|  |
| --- |
|  |
|  |

**ADDITIONAL NOTES/SUMMARY**

| Period of Use: | | | | | |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
|  | | | | | |
|  | | | | | |
|  | | | | | |
| Short Term Plan(s): | | | | 🞏 Trial Equipment : | |  |
| Date/Place: | | |  | | | |
| 🞏 Obtain further info. | | | | |  | |
| 🞏 Other: | |  | | | | |

| Info given to client: | 🞏 Terms and Conditions on delivery of equipment  🞏 Other: |
| --- | --- |
|  |

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