SPECIALISED
WHEELCHAIR COMPANY

REFERRAL FORM

Please complete as much as possible & return to Product Specialist directly or info@swco.com.au
Questions? Please call us on 02 9905 5333.

REFERRER DETAILS

Name:

Organisation:

Email:

Relationship to Client:

Days of work:

Phone No.:

PARTICIPANT INFORMATION

Client Name:

D.O.B:

Email:

Phone no:

Address:

Best days to trial:

Diagnosis/Disability:

Weight in kg:

Support Coordinator/ Plan Manager Name:

Email:

Funding:
- Private
- ENABLE
- NDIS Number:
- Other

Are there any risk factors at the client's home? Dog? Smoker? Aggressive? Remote location?

REFERRAL INFORMATION

HISTORY	TICK	DETAILS
Asymmetrical posture		
Pain		
Pressure injury/skin history		
Muscle tone		
Swallowing/breathing difficulty		
Seizures		
Past/planned surgery		

REASON FOR REFERRAL

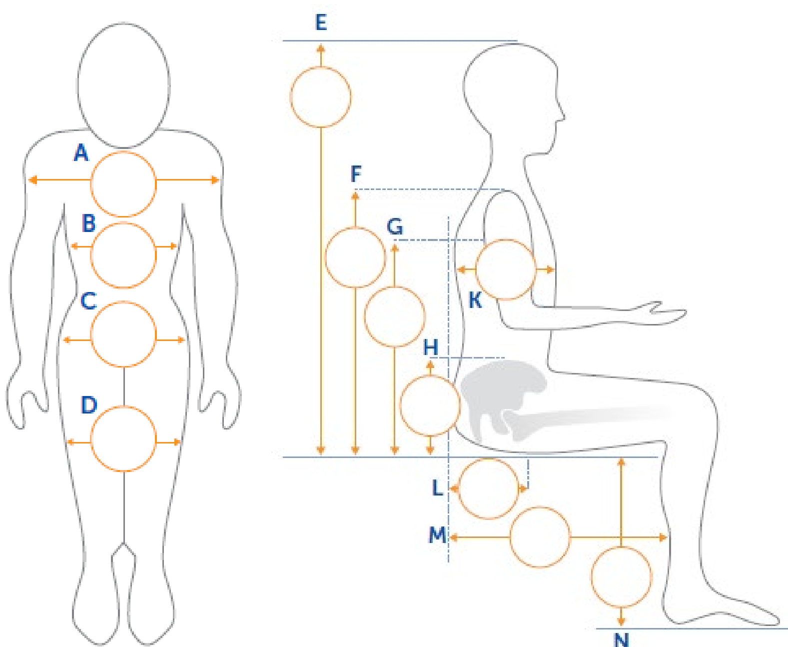
Powered Mobility | Service | Other

Manual Wheelchair | Self-care Products

Seating | Home Automation

Desired features and considerations for equipment:

CLIENT MEASUREMENTS & MAT EVALUATION



A SHOULDER WIDTH
B CHEST WIDTH
C HIP WIDTH
D WIDTH AT KNEE
E SEAT TO TOP OF HEAD
F SEAT TO TOP OF SHOULDER
G SEAT TO AXILLA
H SEAT TO PSIS
K CHEST DEPTH
L BACK TO ANTERIOR OF ITS
M SEAT DEPTH
N SEAT TO FOOT PLATE

MAT EVALUATION NOTES
(please attach form if possible)

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