

GTK Rehab

Rehabilitation Technology Supplier

TO BOOK AN APPOINTMENT WITH OUR STAFF

Complete & return the following form by fax to GTK Rehab. Fax: (02) 9620 9081

Client Information:		Today's Date:	
Name:	M <input type="checkbox"/> F <input type="checkbox"/>	D.O.B: Age:	Height: mm Weight: kg
Address:	PH (Hm):		(W):
	Funding: <input type="checkbox"/> Priv <input type="checkbox"/> PADP <input type="checkbox"/> Other		
Location for appointment:			

Medical Details				DIAGNOSIS/DISABILITY:	
Specify:	Yes	No		Yes	No
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Dislocated hips	L / R	<input type="checkbox"/>
Cardiovascular difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>
Breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	(location & severity)	_____	
Swallowing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Pressure Area(s)	<input type="checkbox"/>	<input type="checkbox"/>
Asymmetrical posture	<input type="checkbox"/>	<input type="checkbox"/>	(location & severity)	_____	
Past / Planned Surgery (List)	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Tone: (Describe)		

Current Seating / Mobility:			
<input type="checkbox"/> Powered Wheelchair Type	Method of Control:		Age/Cond:
<input type="checkbox"/> Manual Wheelchair Type	Self Propelling <input type="checkbox"/> Y <input type="checkbox"/> N		Age/Cond:
<input type="checkbox"/> Special Seating	W/C cushion Type:	W/C back Type:	Extra Equipment:
Approx. Size:	Seat Width:	Seat Depth:	

Concerns regarding their current WC and/or Seating or posture (please list)

Equipment you would like GTK to bring to the appointment

Width of frame: _____

Your Name: _____ Your Role: _____

Your Contact Details Ph: _____ Fax: _____

Thank You. We Will Contact You By 'Phone Or Fax To Arrange A Suitable Time.