MPOT – WHEELCHAIR REVIEW / POSTURAL ASSESSMENT REFERRAL

Person Completing Form:		Date:	
Company:		Contact No:	

CLIENT INFORMATION

Claim Number (if relevant):

Mr/Mrs/Miss/Ms/Dr:		Date of Birth:	
First / Given Name:		Last / Family Name:	
Phone / Mobile:			
Email:			
Address:			
Suburb:		Post Code:	

REFERRAL INFORMATION (IF APPLICABLE)

Referring Agency:	
Contact Name:	
Phone / Mobile:	
Email:	

CLIENT MEDICAL INFORMATION

PRESENTING CONDITION

Include date of onset, diagnosis, symptoms.

HEAD OFFICE
FULLARTON | Ground Floor, 246 Glen Osmond Road, Fullarton SA 5063

REGIONAL OFFICE
TANUNDA | 2 Elizabeth Street, Tanunda SA 5352
PO BOX 534, Tanunda SA 5352

1300 368 141
FAX (08) 8336 6988

ACCESS FITNESS
ABN 11 160 005 514 | info@accessfitness.com.au
www.accessfitness.com.au

MPOT Pty Ltd
ABN 24 109 545 968 | office@mpot.com.au
www.mpot.com.au

CLIENT MEDICAL INFORMATION

PAST MEDICAL HISTORY

SKIN CONDITION

Please include any pressure sore issues.

CURRENT EQUIPMENT IN USE (eg. wheelchair, cushions, headrest, backrest, belt etc)

Please include when equipment was issued / aquired.

FUNCTIONAL ABILITY

Please provide details regarding: Mobility (including using walking aids) and Method of Transfer.

REASON FOR REQUESTING A WHEELCHAIR REVIEW / POSTURAL ASSESSMENT

WHEELCHAIR USAGE – How often is wheelchair likely to be used / is used?

WHEELCHAIR USAGE – Where is the wheelchair likely to be used / is used?

MEDICAL PROVIDERS

GENERAL PRACTITIONER

Doctors Name:	
Business Name:	
Phone / Mobile:	
Email:	
Address:	

SPECIALIST / SURGEON

Specialist Name:	
Business Name:	
Phone / Mobile:	
Email:	
Address:	

PHYSIOTHERAPIST

Therapist Name:	
Business Name:	
Phone / Mobile:	
Email:	
Address:	

ANY ADDITIONAL INFORMATION

WE RECOMMEND SAVING A COPY OF THIS FORM FOR YOUR OWN RECORDS
PLEASE EMAIL FORM AS PDF TO **referrals@mpot.com.au**