

Date: .....

## WHEELCHAIR FORM

Full Name:.....

Dob:.....

Sex:.....

Temp/Perm Adress.....

How long you have been been using assistive device? .....

How did you get into such a condition?

.....  
.....

### Patient measurements

In Cm..... Ich.....

1. Hip width.....

2. Seat Dept.....

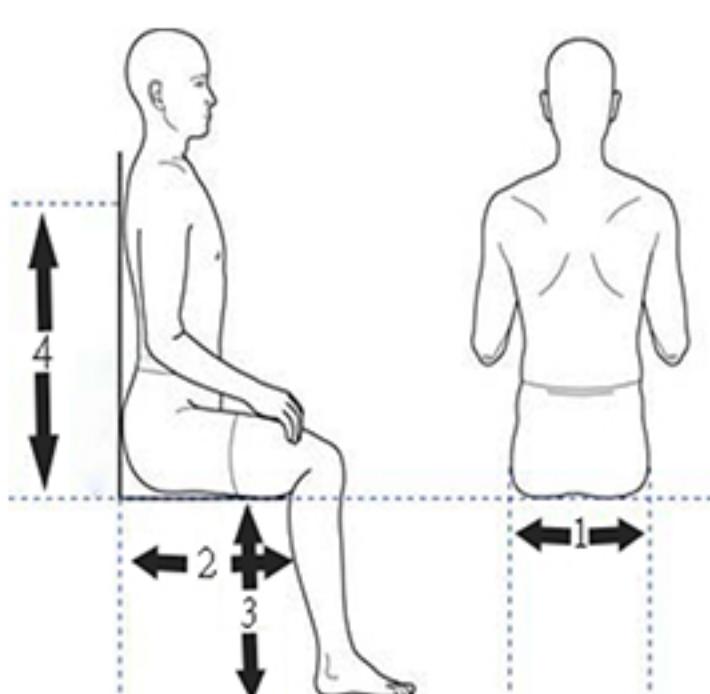
3. Foot drop:

Left leg.....

Right leg.....

4. Top of shoulders to seat

.....



Name of Recommended Person/org:.....

Guardians Name:.....

Applicant Signature:.....