

REFERRAL FORM - MWC

Upon completion please return to: hello@motum.com.au

CLIENT DETAILS

Name: _____ NOK/Guardian name (if applicable): _____

Date of birth: _____ NDIS participant number(if applicable): _____

Contact mobile: _____ Email: _____

Address: _____

If NDIS participant, how are funds managed, or please advise if non-NDIS:

Agency-managed Plan-managed Self-Managed Other: _____

Is provision for this item already included within current NDIS plan? Yes No N/A

Please note that referrals may be declined if client or NOK contact details are not provided as Motum requires this information to share quoting and ordering information.

PRIMARY THERAPIST DETAILS

Name: _____ Organisation: _____

Tel: _____ Email: _____

TRIAL DETAILS

Model(s) to trial (if known): _____

Preferred trial location: Motum Client's home Other: _____

Preferred days of week / times of day : _____

Please note that the wait time for new referral appointments is typically between 2-4 weeks (Perth Metro area) and 4-8 weeks (regional areas), however, at times, it may be longer, particularly when client/primary therapist availability is limited.

MEASUREMENTS

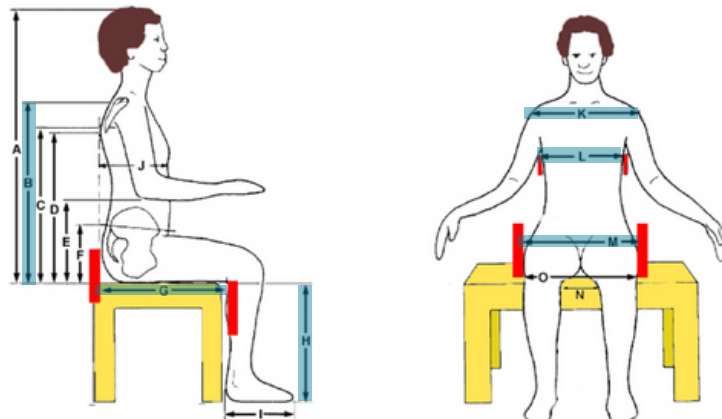
Do you need a Motum therapist to assist with a postural assessment? Yes No *Please note there will be a clinical charge for this service if required.*

Hip / Thigh width (M): _____ Seat depth (G): _____ (Left) _____ (Right)

Shoulder width (K) : _____ Chest width (L): _____

Back height (B): _____ Lower leg length (H): _____

Current weight _____ kg



Please note that while Motum will always try to meet the requirements specified above for a wheelchair trial, an exact match may not always be possible due to the level of customisation required for an individual and/or the availability of demo models.

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MANUAL WHEELCHAIR SPECIFICATIONS

FEATURES, OPTIONS & ACCESSORIES

| | | | | |
|------------------|-----------|---------------|----------------|--------|
| Propulsion-style | Attendant | Self-propel | Both | |
| Frame type | Rigid | Folding | | |
| Function type | Active | Tilt in Space | Occasional use | Unsure |

Other desired features: _____

| | | | | | |
|----------------|-------|------------|---------|-----------|---------|
| Leg rest style | Fixed | Swing away | Flip-up | Elevating | Dynamic |
|----------------|-------|------------|---------|-----------|---------|

| | | | |
|----------|---------------------|------------|--------------|
| Armrests | Flip up / Removable | Desk style | Other: _____ |
|----------|---------------------|------------|--------------|

| | | |
|---|-----|----|
| Does the MWC need to be transport compliant | Yes | No |
|---|-----|----|

POSTURAL SUPPORT REQUIREMENTS

Base cushion: _____

Backrest: _____

Pelvic belt: _____

Headrest: _____

Chest / Lateral support: _____

POWER ASSIST

| | | |
|--|-----|----|
| Would you also like to trial power assist options? | Yes | No |
|--|-----|----|

(If you are wishing to trial power assist with an existing chair, please confirm make, model and seat width in the notes below)

Preferred style:

| | | |
|-------------------|-------------|--------------|
| Joystick operated | Left-handed | Right-handed |
|-------------------|-------------|--------------|

Notes: _____

(Eg. Alber E-Fix, Pride Power Assist, Glide Joy)

Rear add-ons

Notes: _____

(e.g. Smartdrive / SMOOV)

Wheel-based/ Self-propel options

Notes: _____

Eg. E-motion, Glide Push Assist)

Front add-ons

Notes: _____

(e.g. Triride / Batec / Klaxon / Blumil Go)

Any other details relating to the client's situation/diagnosis that may be of relevance when trialling/scripting the these items

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