

## Client details

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First name:

Last name:

Date of birth:

Gender:  M  F  Other

## Home

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Name:

Telephone:

Clinical lead:

Address:

## Client information

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Height:

Weight:

Diagnosis:

Skin integrity:

Pain:

Physical presentations:

Communication:

Cognition:

Challenging behaviour:

Hearing:

Sight:

Perception:

## Mobility

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Equipment used:

Transfers

Independent  Dependent

Equipment and transfer method used:

Other considerations:

## Goals

Client goals	Home goals

## Current equipment in use

Main chair:	Cushion:	Accessories:
Make	Make	
Model	Model	
Date issued	Date issued	Date issued
Issued by	Issued by	Issued by

## Recommendation

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Seat height:

Seat width:

Seat depth:

Armrest height:

Pressure relief:

Other recommendations:

Clinical justification:

Date of assessment:

Assessed by: