|  |  |  |
| --- | --- | --- |
| DOB |    | PID Number |
| Gender |   |   |
| Title |   | Surname |   |
| Given Names |   |
| Address |   |
|  | *(Type or affix sticker)* |

The above client has expressed an interest to operate a Powered Wheelchair or Mobility Scooter.

As for driving a car, a person needs certain physical and mental attributes to use a motorised mobility device safely:

**Adequate vision** - for environment scanning and avoiding hazards, like pedestrians and vehicles.

**Cognitive capacity** - concentration, clear thinking, planning, problem-solving, ability to learn new tasks, and react in a timely way to traffic situations.

**Physical capacity** - upper limb strength, hand function to operate controls, sitting balance, neck range of movement, ability to get on and off the device.

**Ability to communicate** - in some way with other pedestrians/public transport staff etc.

**Well controlled medical conditions** - stable diabetes, controlled seizures.

Reference: <https://www.vicroads.vic.gov.au/-/media/files/documents/safety-and-road-rules/motorised-mobility-devices/motorised-mobility-devices-fact-sheet-for-gp-practices-motorised-mobility-devices.ashx>

In order for Silver Chain to assist with the purchase or hire of this device, we shall require the client’s Medical Practitioner to complete the following form and advise about medical conditions that may impact on or preclude the client’s ability to safely use an MMD.

Following the Medical Practitioners endorsement, the Silver Chain Occupational Therapist will then proceed to a practical trial of a MMD with the client.

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| **SECTION 1. CLIENT INFORMATION – see client label above**  |
| Owns a drivers license:  | [ ]  YES | [ ]  NO |
| If Yes, please list any restrictions:       |
| **SECTION 2. DIAGNOSES AND CLINICAL CONDITIONS** |
| **A. MEDICAL INFORMATION** |
| Any presence of the following conditions:Diabetes mellitus:Epilepsy:Dizziness / Vertigo:Blackouts:Cardiovascular conditions:Hearing impairment:Musculoskeletal conditions:Neurological conditions:Psychiatric conditions:Impulsive behaviour:Sleep disorders:Substance misuse (including alcohol, illicit drugs and prescription drugs)Vision and eye disorders:Intellectual disability:Cognitive impairment: Prescribed drugs that may affect ability to operate an MMD:Other condition, medical needs or consideration that may affect ability to safely operate a MMD: | [ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES[ ]  YES | [ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO[ ]  NO |
| If you answered ‘Yes’ to any of the above, please provide additional detail in regard to how this may impact the client’s ability to use a MMD.      |

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| **B. EYESIGHT STATUS** |
| **Visual acuity:** | R:       | L:       |
| **Binocular vision:** | Unaided: 6/       | Aided: 6/       |
| **Is the client required to wear glasses, contact lenses or other visual aids to correct visual difficulties?** | [ ]  YES | [ ]  NO |
| If Yes, please provide details:       |
| **Is the client required to wear any of the above to operate a MMD?** | [ ]  YES | [ ]  NO |
| If Yes, please provide details:       |
| Visual fields: | [ ]  Normal | [ ]  Abnormal |
| Comments:       |
| **Does the client experience following conditions:** |
| Diplopia, nystagmus, loss of an eye, fluctuating vision, cataracts, glaucoma, retinitis pigmentosa, poor night vision | [ ]  YES | [ ]  NO |
| Any other visual difficulties that may impact on MMD use:      |
| If Yes, please provide details:       |
| *If you have concerns regarding the above, consider referral for an optometrist/ophthalmologist assessment* |
| **C. MOBILITY STATUS** |
| **Maximum distance client can walk:** | Unaided:      metres | Aided:      metres |
| **Client’s weight:**      kg | **Client’s height:**      cm |
| **D. PROGNOSIS** |
| **In your opinion, is the client’s cognitive, visual and/or physical status likely to change in 2 years and affect his/her ability to safely use the MMD?**  | [ ]  YES | [ ]  NO |
| If Yes, please provide details:       |
| **Will the use of a MMD impact negatively on the client’s health or fitness level?** | [ ]  YES | [ ]  NO |
| If Yes, please provide details:       |

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| **3. ADDITIONAL COMMENTS** |
| **Please provide any additional comments that you think may be relevant to the use of a MMD:**       |
| **4. DECLARATION** |
| **I declare that I have reviewed the questionnaire with the client and:** |
| [ ]  Do not have concerns about the client’s ability to safely use a MMD. Further assessment by a suitability qualified prescriber is required to determine whether a MMD would best meet the client’s mobility needs.[ ]  Have concerns about the client’s ability to safely drive a MMD in the community. |
| **5. MEDICAL PRACTITIONER INFORMATION** |
| **Name of medical practitioner:**       |
| **Provider number:**       |
| **Address:**       |
| **Phone number:**       |
| **Signature:**  | **Date:**       |