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Trial Booking

Prescription Form

staebel

Form Information

Dealer Information						
Date of Birth	/ /	Sales Rep				
Street Address		Email				
Suburb		Phone				
Postcode	State	Fax				

Client Informat	ion									
Date		/	/		Fu	III Name				
Contact					St	reet Address				
Funding Number					Su	ıburb				
Plan Date - Start to Finish			to		Pc	ostcode		State		
Plan Manager					CI	ient Weight			kg	
Funding Type										
M.A.S.S.			NDIS			Homecare Package	Otł	ner:		

Support Coordinator Information							
Date	/	/		Email			
Full Name				Street Address			
Organisation				Suburb			
Mobile				Postcode		State	
Office Phone							

Comments

Trial Information

Does the equipment consultant need to be present?		Yes		No	
Prescriber/Clinician Information					
Full Name					
Phone					
Email					

Availability for Trial – Week Day Only								
	Monday	Tuesday	Wednesday	Thursday	Friday			
From								
То								
Location for Trial								
	Home		Showroom		Office Address			

Access Details (Parking available, recommended access, Narrowest doorway, steep driveway, stairs ect)

Accessibility Details (Mobility aids used, transfer aids required eg hoist ect)

People Present at the trial (Client, OT, Carer, Family ect)

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Equipment Request Details

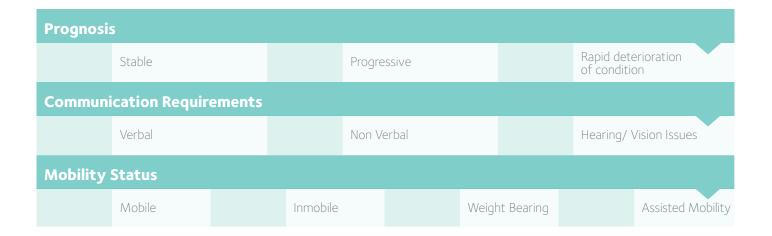
Dimensions (mm), Specific clinical requirements & Details (of equipment you would like to trial)

Additional Equipment Required (If requesting hoist, check bed dimensions ect)

Current equipment in use and issues regarding it

Client Assessment Information

Client Goals & Requests (What do they want to achieve with our AT Equipment?)



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Client Assessment Information Cont.

Client Measurements						
kg	Weight	mm	Height			
mm	Lower Leg Length	mm	Coccyx to top of head			
mm	Hip Width	mm	Upper Leg Length			
mm	Popliteal Height					

Pressure Risk Information (existing pressure wound, prone to pressure injuries ect)

Comments

Save As

Print



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