**DFC Equipment Program:** Adults

**Scooter Assessment Form**



**Complete eligibility screen before proceeding with this prescription**

| Name: |  | | | | | | | Sex: 🞏 M 🞏 F | | | | | DOB: |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address: | |  | | | | | | | Phone No: | |  | | | |
| Clinician: | | |  | | | Agency: | | | |  | | | | |
| Scooter being considered: 🞏3W 🞏4W | | | | |  | | Assessment Date: | | | | |  | | |
| People consulted: | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | |



## MEDICAL HISTORY

| Diagnosis/onset: | |  | | | | |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | 🞏 Stable 🞏 Deteriorating | | |
| Current medications: | | |  | | | |
|  | | | | | | |
| Medical officer: |  | | | | Ph: |  |

## SOCIAL HISTORY

| 🞏 Lives alone 🞏 Spouse 🞏 Other family 🞏 Friend 🞏 Other | | | | | | | | | |  | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Carer’s general health (if applicable) | | | |  | | | | | | | | |
| Accommodation: 🞏 Home/unit 🞏 Retirement village 🞏 Hostel 🞏 Other | | | | | | | | | | | |  |
| Ownership: 🞏 Owner 🞏 Rents 🞏 Housing SA 🞏 Other | | | | | | | |  | | | | |
| Storage site & recharging arrangements: | | | | |  | | | | | | | |
| *(For recharging the battery an extension cord of 3m can be used, but it must remain in the same building)* | | | | | | | | | | | | |
| Does client understand the recharging requirements? 🞏 Yes 🞏 No | | | | | | | | | |  | | |
| Is the area lockable? 🞏 Yes 🞏 No | | | | | | | | | | | | |
| Intended use of scooter: 🞏 Home (internal) 🞏 Home (external) 🞏 Community 🞏 Shops 🞏 Work | | | | | | | | | | | | |
| 🞏 Other |  | | | | | | | | | | | |
| Comments on local terrain and access to property: | | | | | |  | | | | | | |
| Areas where scooter usage will need to be assessed: | | | | | | |  | | | | | |
|  | | | | | | | | | | | | |
| Estimated distance travelled per day: | | | |  | | | | | | | | |
|  | | | | | | | | | | | | |
| Driver’s license held: 🞏 Never 🞏 Not Current 🞏 Current | | | | | | | | |  | | | |
| If client has stopped driving, why? | | |  | | | | | | | | | |
|  | | | | | | | | | | | | |
| Transportation of scooter: 🞏 Car 🞏 Van 🞏 Bus 🞏 Taxi 🞏 Other | | | | | | | | | | |  | |
| Details: | |  | | | | | | | | | | |

#### PHYSICAL EVALUATION

| Height: |  | | Weight: | | |  | | | Pain: | | | 🞏 Present 🞏 Absent | | |  | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Pressure Care - are there any issues? | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Ambulation status (note if aid used): | | | | | | |  | | | | | | | | | |
| Transfers: | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Lower Limb function (ROM, strength, balance): | | | | | | | | | | |  | | | | | |
| Balance/trunk control (static and dynamic): | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Upper Limb Function (dexterity, coordination, strength, etc.): | | | | | | | | | | | | | | 🞏 Right handed 🞏 Left handed | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Head/neck (note ROM): | | | | |  | | | | | | | | | | | |
| Bladder management: 🞏 Independent 🞏 Assisted 🞏 Dependent | | | | | | | | | | | | | | | |  |
| Bowel management: 🞏 Independent 🞏 Assisted 🞏 Dependent | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| Hearing: 🞏 Normal 🞏 Impaired 🞏 Deaf | | | | | | | | | | | |  | | | | |
| Visual history/aids: | | | |  | | | | | | | | | | | | |
| Visual acuity/fields: 🞏 Normal 🞏 Impaired | | | | | | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |

###### COGNITION and PERCEPTION

| Insight: |  | | | | Learning ability: |  | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Impulsiveness/response time/safety awareness: | | | |  | | | |
|  | | | | | | | |
| Planning/problem solving: | |  | | | | | |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |
| Attention/concentration/memory: | | |  | | | | |
|  | | | | | | | |
|  | | | | | | | |
| Is further assessment/referral to another discipline required? 🞏 Yes 🞏 No | | | | | | |  |
|  | | | | | | | |
|  | | | | | | | |
|  | | | | | | | |

## SCOOTER HISTORY

| Type: |  | | Period of use: |  |
| --- | --- | --- | --- | --- |
| Specifications/condition/problems: | |  | | |
|  | | | | |
|  | | | | |
|  | | | | |

## CLIENT GOALS and CONCERNS

| Period of Use: |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |

## ADDITIONAL NOTES/SUMMARY

| Period of Use: |
| --- |
|  |
|  |
|  |
|  |
|  |

| Short Term Plan(s): | | | |  | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | |
| Scooter recommended for trial: | | | | | |  | | |
| Date: |  | | | | | | Location: |  |
| Has Medical Clearance been received from Doctor? 🞏 Yes 🞏 No | | | | | | | | |
|  | | | | | | | | |
| 🞏 Obtain further info | | | | |  | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| 🞏 Other: | |  | | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |

| Info given to client: | 🞏 DFC Equipment Fact Sheet | 🞏 ILC Information sheet |
| --- | --- | --- |

| **Clinician’s Name:** |  |  |  |
| --- | --- | --- | --- |
| **Clinician’s Signature:** |  | **Date:** |  |