GMobility pty. ltd
www.gmobility.com.au

Wheelchair Seating Assesment Form

Therapist Information

Name ______________________

Organisation ______________________

Contact Phone ______________________

Email Address ______________________

Client Information

First Name ______________________

Last Name ______________________

Diagnosis: ______________________

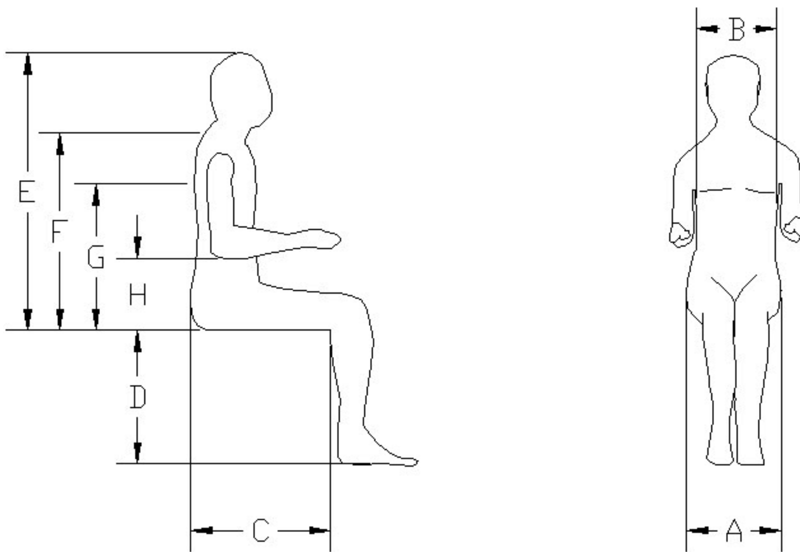
Funding Source: ______________________

Client Age: ______________________

Weight ______________________

Height ______________________

Client Measurements



A - Hips or Thighs (Widest Point)* __________

B - Torso Width (Widest Point) __________

C - Posterior of buttocks to back of knee* __________

D - Back of Knee to Heel* __________

E - Seat to Top of Head __________

F - Seat to Top of Shoulders __________

G - Seat to Base of Scapula* __________

H - Seat to Elbow __________

*** Required Field**

Client Wheelchair Requirements

	Yes	No
Light Weight	◯	◯
Foldable	◯	◯
Tilt in space	◯	◯

Manual ◯ Electric ◯

Plase provide any relevant details about the clients pressure care requirements. (History of pressure areas, ability to shift weight, prolonged sitting, continent, sensory impairment.)