

Please complete as much as possible & return to [solutions@24hp.com.au](mailto:solutions@24hp.com.au).  
 Questions? Please call us on 02 9161 2626.

## REFERRER DETAILS

Name: Relationship to Client:  
 Organisation: Days of work:  
 Email: Phone No.:

## PARTICIPANT INFORMATION

Client Name: Diagnosis/Disability:  
 D.O.B: Weight in kg:  
 Email: Support Coordinator/  
 Plan Manager Name:  
 Phone no: Email:  
 Address:  
 Best days to trial: Funding: Private  
 Self Managed - Client pays 24HP directly ENABLE  
 Plan Managed NDIS Number:  
 NDIS Managed Other

Are there any risk factors at the client's home? Dog? Smoker? Aggressive? Remote location? Any religious or cultural needs that should be considered?

## REFERRAL INFORMATION

HISTORY	TICK	DETAILS
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Asymmetrical posture		
Pain		
Pressure injury/skin history		
Muscle tone		
Swallowing/breathing difficulty		
Seizures		
Past/planned surgery		

## REASON FOR REFERRAL

Custom Moulded Seating

Sleep Positioning

Other

Wheelchair/Seating Assessment

Pressure Care

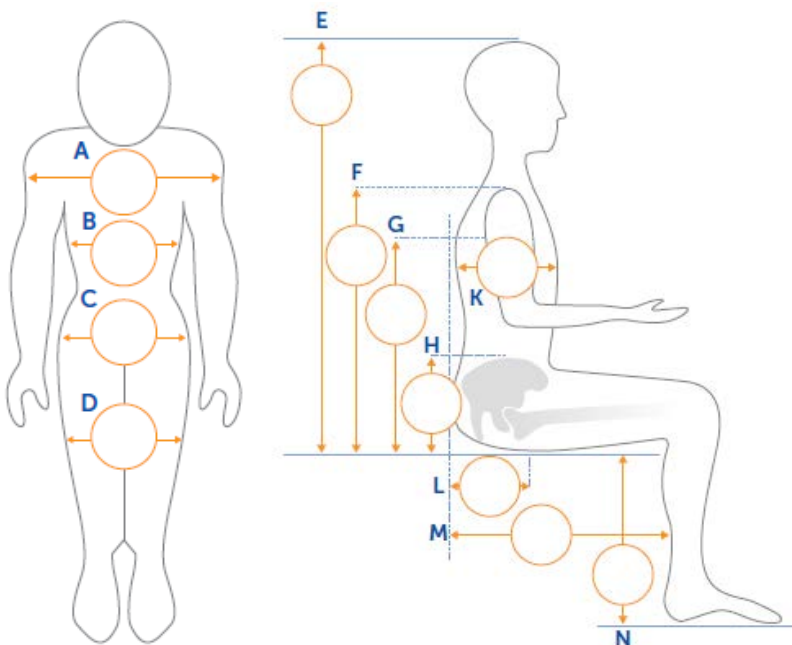
Pressure Mapping

AT Assessment

Desired features and considerations for equipment:

Current equipment:

## CLIENT MEASUREMENTS & MAT EVALUATION



- A** SHOULDER WIDTH
- B** CHEST WIDTH
- C** HIP WIDTH
- D** WIDTH AT KNEE
- E** SEAT TO TOP OF HEAD
- F** SEAT TO TOP OF SHOULDER
- G** SEAT TO AXILLA
- H** SEAT TO PSIS
- K** CHEST DEPTH
- L** BACK TO ANTERIOR OF ITS
- M** SEAT DEPTH
- N** SEAT TO FOOT PLATE

### MAT EVALUATION NOTES

(please attach form if possible)