Mobility Device Service registration form

1. Service information

Person completing the form:		Date:	
Service provider:			
Referral source:			

2. Client information

Title		First names:	
Surname:		Date of Birth:	
Address:			
Village:		Island of residence:	
Province:		Island of origin:	
Phone number:		Additional contact info:	

3. Demographics

Gender:	Male ☐ Female ☐	Age:	0-5 ☐ 6-18 ☐ 19-39 ☐ 40-54 ☐ 55+ ☐

4. Existing device and diagnosis

Does the client have an existing device?	Yes ☐ No ☐
If yes, what type of device?	Wheelchair ☐ Walking Aid ☐ Type: _____ Orthosis ☐ Prosthesis ☐ Other: _____
Was the device provided by this Service?	Yes ☐ No ☐
If no, who provided the device?	
Did you or your family pay for the device?	No ☐ Yes ☐ If yes, how much? _____

What is your diagnosis? *(tick all relevant)*

Diabetes ☐	Spinal Cord Injury ☐	TB Spine ☐
Stroke ☐	Brain Injury ☐	Frail old age ☐
Arthritis ☐	Spina Bifida ☐	Cerebral Palsy ☐
Fracture ☐	Congenital deformity ☐	Infection ☐
Traumatic amputation ☐	Unknown diagnosis ☐	

Other: _____

Lower limb amputation ☐		Upper limb amputation ☐	
Transfemoral (above knee)	L ☐ R ☐	Transhumeral (above elbow)	L ☐ R ☐
Transtibial (below knee)	L ☐ R ☐	Transradial (below elbow)	L ☐ R ☐
Partial foot	L ☐ R ☐		

Other information: