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Powered Wheelchair & Mobility Scooter Medical Consent Form

The completion of this form by a medical practitioner will help to inform our clinicians' comprehensive clinical assessment of this consumer, who wishes to use a powered wheelchair or mobility scooter for personal use.

Consumer Information

First Name:
Surname:
Date of Birth:

Physical Status – Please circle:

Transfers and ambulation	Independent	Requires assistance	Aids:
Hearing	Intact	Impaired	Aids: Yes / No
Vision	Intact	Impaired	Glasses / contacts: Yes / No

Safe Usage

Q1. Does the consumer have any medical conditions that may impact their ability to use a powered wheelchair/mobility scooter? Please tick

Medical Condition	**YES**	**NO**
Cognitive impairment (i.e. dementia)		
Diabetes		
Epilepsy		
Giddiness		
Blackouts		
Fainting		
Sudden episodes of unconsciousness		
Progressive eye condition		
Restricted neck/head movements		
Progressive neuromuscular disorder		

Q2. Are you aware of any medical conditions that would prevent the person from holding a driver's license? **Yes** ☐ **No** ☐

Q3. Are you aware of any history of near misses or accidents while driving a car? **Yes** ☐ **No** ☐

Relevant Medication

Consent

Q1. In your opinion, is this consumer's cognitive, visual, and/or physical status likely to affect his/her ability to use a powered wheelchair/mobility scooter safely within the next two years? **Yes** ☐ **No** ☐

Q2. In your opinion, will using a powered wheelchair/mobility scooter negatively impact the person's health and well-being? **Yes** ☐ **No** ☐

Additional Comments

Please provide any additional comments that you feel may be relevant to this consumer using a powered wheelchair/mobility scooter:

Declaration

I declare that I have completed the above information and pending the outcome of further assessment completed by a qualified allied health professional to determine the best item to meet their mobility needs:

- ☐ *I DO NOT have concerns about this consumer's ability to safely use a powered wheelchair/mobility scooter in the RACF.*
- ☐ *I DO NOT have concerns about this consumer's ability to safely use a powered wheelchair/mobility scooter outside the RACF in the community.*
- ☐ *I DO have concerns about this consumer's ability to safely use a powered wheelchair/mobility scooter in the RACF.*
- ☐ *I DO have concerns about this consumer's ability to safely use a powered wheelchair/mobility scooter outside the RACF in the community.*

Name of Medical Practitioner:	*Signature of Medical Practitioner:*
Medical Practice:	*Contact Number:* *Contact Email:*
Date:	