Evaluation Form

Therapist's Name:______________________________Email_________________________
Phone#_____________________________Fax#____________________________________
Mailing Address:____
City, State, Zip:____
Therapist Diagnosis:____
Expected Growth Rate:____
Passenger's Name:__________________ Family Name:___________________________

Modifications & Custom Work For A Better Fit

"Please answer the following questions so we can assist you with the best fit"

Please Circle Answer

1. Back Brace? Yes or No
2. Spinal Rod? Yes or No
3. Head Halo? Yes or No
4. Head Control? Yes or No

Please Circle Answer

5. Torso Control? Yes or No
6. Limb Control? Yes or No
7. Wind Swept Legs? Yes or No
8. Siezures? Yes or No

Therapist or Seating Specialist – Please make your recommendations

Mobility Push Chairs	**Color**	**Model#**	**Quantity**
Axiom 1.5	Red	16"IOM-1.5-09R	
Axiom 1.5	Navy	16"IOM-1.5-09N	
Axiom 2	Red	16"IOM-2-04R	
Axiom 2	Navy	16"IOM-2-04N	
Axiom 3	Red	16"IOM-3-04R	
Axiom 3	Navy	16"IOM-3-04N	

Accessories	**Color**	**Model#**	**Quantity**
Bug Canopy All Sizes	Mesh	ASC-SB2-040	
Sheerling Insert All Sizes	Natural	ASI-DB-040	
Flashing Light	Red	AFL-04R	
Bunting Bag All Sizes	Silver	ABB-07R	

We strive to provide the best fit for the passenger. If you have a special request please let us know. We often can make modifications at an additional cost. ____________________________
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