

Wheelchair follow up form

This form is for recording information from a follow up visit.

1. Wheelchair user information

Wheelchair user name: Hala _____ Number: _____

Date of fitting: _____ Date of follow up: _____

Name of person carrying out follow up: _____

Follow up carried out at: User's home Wheelchair service centre Other: _____

2. Interview

**Record action
to be taken:**

Are you using your wheelchair as much as you would like?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – why not?		
Do you have any problems using your wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes – what are the problems?		
Do you have any questions about using your wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes – what questions? Is further training needed?		
Does the wheelchair user have any pressure sores?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Describe (location and grade)		
How would you rate your satisfaction with your wheelchair from 1-5? (1 is not satisfied and 5 is very satisfied)	Rate:	
Comment:		

3. Wheelchair and cushion check

Is the wheelchair in good working order and safe to use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the cushion in good working order and safe to use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no for either, what is the problem?		

4. Fitting check

Does the wheelchair fit correctly?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – what is the problem?		
Pressure test level (1 = safe, 2 = warning, 3 = unsafe) (if user at risk of developing a pressure sore)	Left:	
	Right:	
Is the wheelchair user sitting upright comfortably when still, moving, and through the day?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – what is the problem?		

Wheelchair follow up form

This form is for recording information from a follow up visit.

I. Wheelchair user information

Wheelchair user name: Daarun Number: _____

Date of fitting: _____ Date of follow up: _____

Name of person carrying out follow up: _____

Follow up carried out at: User's home Wheelchair service centre Other: _____

2. Interview

**Record action
to be taken:**

Are you using your wheelchair as much as you would like?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – why not?		
Do you have any problems using your wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes – what are the problems?		
Do you have any questions about using your wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes – what questions? Is further training needed?		
Does the wheelchair user have any pressure sores?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Describe (location and grade)		
How would you rate your satisfaction with your wheelchair from 1-5? (1 is not satisfied and 5 is very satisfied)	Rate:	
Comment:		

3. Wheelchair and cushion check

Is the wheelchair in good working order and safe to use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the cushion in good working order and safe to use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no for either, what is the problem?		

4. Fitting check

Does the wheelchair fit correctly?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – what is the problem?		
Pressure test level (1 = safe, 2 = warning, 3 = unsafe) (if user at risk of developing a pressure sore)	Left:	
	Right:	
Is the wheelchair user sitting upright comfortably when still, moving, and through the day?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – what is the problem?		

Wheelchair follow up form

This form is for recording information from a follow up visit.

1. Wheelchair user information

Wheelchair user name: Talha Number: _____

Date of fitting: _____ Date of follow up: _____

Name of person carrying out follow up: _____

Follow up carried out at: User's home Wheelchair service centre Other: _____

2. Interview

**Record action
to be taken:**

Are you using your wheelchair as much as you would like?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – why not?		
Do you have any problems using your wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes – what are the problems?		
Do you have any questions about using your wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes – what questions? Is further training needed?		
Does the wheelchair user have any pressure sores?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Describe (location and grade)		
How would you rate your satisfaction with your wheelchair from 1-5? (1 is not satisfied and 5 is very satisfied)	Rate:	
Comment:		

3. Wheelchair and cushion check

Is the wheelchair in good working order and safe to use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is the cushion in good working order and safe to use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no for either, what is the problem?		

4. Fitting check

Does the wheelchair fit correctly?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – what is the problem?		
Pressure test level (1 = safe, 2 = warning, 3 = unsafe) (if user at risk of developing a pressure sore)	Left:	
	Right:	
Is the wheelchair user sitting upright comfortably when still, moving, and through the day?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If no – what is the problem?		