HealthCheckSystems.com
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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				Please Circle Answer		
1. Back Brace?	Yes	or	No	5. Torso Control?	Yes	or	No
2. Spinal Rod?	Yes	or	No	6. Limb Control?	Yes	or	No
3. Head Halo?	Yes	or	No	7. Wind Swept Legs?	Yes	or	No
4. Head Control?	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. _____
_____
_____
_____