saba

NINEWELLS HOSPITAL MOBILITY REGISTRATION FORM

PLEASE USE BLOCK CAPITALS WHEN COMPLETING THE APPLICATION

*NAME:

*DATE OF BIRTH:

*ADDRESS:

*POSTCODE:

*TELEPHONE:

*E-MAIL:

*Must complete all sections

1. Have you ever used a wheelchair or scooter?
   ☐ never ☐ wheelchair ☐ scooter
2. Have you used a scooter or wheelchair in the past 12 months? ☐ yes ☐ no
3. What is your height? ..... What is your weight? ☐ up to 12st ☐ 12-18st ☐ over 18st
4. Are you ☐ left-handed or ☐ right handed?
5. Is your eyesight? ☐ good ☐ fair ☐ poor ☐ visually impaired
6. Is your hearing? ☐ good ☐ fair ☐ poor
7. Can you walk? ☐ yes ☐ a little ☐ no ☐ with sticks/frame
8. Can you stand to transfer? ☐ yes ☐ no
9. Can transfer sitting down? ☐ yes ☐ no
10. If you transfer do you need help? ☐ yes ☐ no
11. Please state the nature of your mobility problem.

12. Do you have a tremor or uncoordinated movement? ☐ yes ☐ no
13. Do you have difficulty getting in and out of a chair? ☐ yes ☐ no
14. Please describe your limb functions.
    Joint movement: ☐ good ☐ fair ☐ poor Muscle strength: ☐ good ☐ fair ☐ poor
    Sitting balance: ☐ good ☐ fair ☐ poor Hand functions: ☐ good ☐ fair ☐ poor
15. Do you have any additional requirements? Please specify, e.g. walking stick, zimmer frame etc.

16. Are you likely to require a scooter or wheelchair within the next 12 months? ☐ yes ☐ no
    If you say no, the above information will be removed from our systems after 1 month.
    If you say yes, your information will be saved in our systems for up to 12 months.
17. Can we keep your information on a contractual basis? ☐ yes ☐ no

☐ I agree to the terms and conditions.

SIGNATURE: