WESTMARC [redacted]
[redacted]

Reporting Form

For use when there are difficulties with a patient's existing equipment

Patient's Name:		DOB	
Patient's Address:			
Address for Review:			
Diagnosis: ***			

Reporter's Name:		Designation	
Address:			
Contact Tel. No.		Date:	

Wheelchair associated with Problem:

Manual:	
Powered:	
Buggy:	

Are the difficulties due to a change in the patient's clinical condition?

Yes	
No	

Would you like a member of WESTMARC clinical/technical Staff to visit the patient?

Yes	
No	

Nature of Patient's Difficulties:

NOTES:* THIS SECTION MUST BE COMPLETED OR FORM WILL BE RETURNED**

Wheelchair repair should be [redacted]

New patients should be [redacted]

Urgent reports should [redacted]

Has the Patient/Parent/Guardian/ Carer agreed to this Review?

Yes	
No	

Does a family Member, Carer, or Guardian wish to attend the Review?

Yes	
No	

Type of adaptation requested (If known, please indicate what type of adaptation is required, and give relevant details)

	ف	**Details of adaptation**
Change in wheelchair size:		
Change in wheelchair type:		
Change in wheel size:		
Change to lighter wheelchair:		

Supply lap strap:		
Supply stump board:		
Supply tray:		
Supply pump for tyres:		
Supply seat cushion:		
Fit extended brake lever:		

Replace lost/stolen equipment (specify item and reason why a replacement is requested):		
Repair to worn equipment (specify item):		
Other:		

Is this a request that should be treated as a priority?

Yes	
No	

If 'yes' give reason

- Wheelchair repair should be [illegible]
- New patients should be [illegible]
- Urgent reports should be [illegible]