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| **POSTURAL MANAGEMENT (LYING) ADVISORY SERVICE REFERRAL****This service is available for EMS assessors in the Waikato, BOP & Lakes regions.**Please send your referrals to:P O Box 5725, Frankton, Hamilton ⚫ Ph 07 848 1825 ⚫ Fax 07 848 1439 ⚫ Email: hamilton@seatingtogo.co.nz |
| **Please contact the Seating To Go General & Training Manager if you have any queries.** |
|  |
| **Therapist Information:** |  |
| **Name:** |  |  |  | **Ph:** |  | **Mob:** |  |
|  | *(first)* |  | *(Surname)* |  |
| **Work Address:** |  | **Email:** |  |
| **Employed by:** | **[ ]**  | **MOH Provider** | **[ ]**  | **MOE** | **[ ]**  | **Specialist School** | **[ ]**  | **Private**  |
| **Area:** | **[ ]**  | **Waikato** | **[ ]**  | **BOP** | **[ ]**  | **Lakes** |  |  |
| **Indicate area of credential if applicable:** | **[ ]**  | **Level 1 WMPM** | **[ ]**  | **Lying** | **[ ]**  | **Level 2 WMPM** |
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|  |
| **Client Related Information:** |  |
| **Client Name:** |  |  |  |  |  |
|  | *(first)* |  | *(Surname)* | *(Title)* |
| **Date of Birth:** |  | **NHI No:** |  | **[ ]**  | **Male** | **[ ]**  | **Female** |
| **Address:**  |  |  |
| **Phone Number: (Hm)** |  | **(Wk)** |  | **(Mob)** |  |  |
|  |
| **Complete all sections (please print clearly)** |
| **Advice required:** | **Current Level of Mobility:** |
| **[ ]**  | Joint assessment |  |
| **[ ]**  | Advice on equipment/trial set up |
| **[ ]**  | Other (specify below) |
|  |
|  |
| **Disability / Health Issues:** | **Describe Current Positioning Equipment:** |
| (Diagnosis if known) |  |
|  |  |
| **Additional relevant Information:** Please attach any assessments of photographs that may assist with planning. |
|  |
| **Therapist Signature:** |  |  |  | **Date:** |  |  |