Freedom Wheels Bike Clinic Application Form

Telephone: (03) 9853 8655 or 1300 663 243 Fax: (03) 9853 8098
C/- Royal Talbot Rehab. Centre, 1 Yarra Boulevard, Kew VIC 3101
E-mail: info@solve.org.au Web site: www.solve.org.au

It is important to provide as much information as possible to questions 4 through 12 to assist us to set up the bike ready for the clinic.

1. Client: _____ male / female D.O.B.: _____

Phone: Home: _____ Work: _____ Mobile: _____

Language spoken at home: _____ E-mail: _____

Address: _____

_____ Postcode: _____

Diagnosis: _____ ☐ Aboriginal / Torres Strait Islander

2. Parents/Carer: _____ Relationship: _____

Phone: Home: _____ Work: _____ Mobile: _____

Language spoken at home: _____ E-mail: _____

Address: _____

_____ Postcode: _____

Main Client Contact: Client / Parent / Carer / Agent (please circle)

3. Referrer/ therapist: _____ Role: _____

E-mail: _____ Phone: Wk: _____ Mobile: _____

Address: _____

_____ Postcode: _____

Do you give permission for Solve Disability Solutions Project Coordinator / Occupational Therapist to contact your therapist? Yes /No

4. Have you ever ridden a bike/trike? Yes / No. Please detail (attach image if current)

Details of riding history / experience. What has been successful, what have been the limitations?

_____

_____

_____

5. Rider specifics: Weight: _____kg **Height:** _____cm **Inner Leg length:** _____.cm

(NB minimum inner leg length for riding is 36cm measured from inner groin to heel of foot. For leg lengths shorter than this please contact Solve)

6. Current Mobility: (tick appropriate box/es)

☐ Walks unaided ☐ Walks with a stick ☐ Walks with a frame

☐ Wheelchair, manual, user-propelled ☐ Wheelchair, manual, attendant propelled

☐ Wheelchair, electric, self-controlled ☐ Wheelchair, electric, attendant controlled

☐ Postural Supports required in wheelchair (*please circle relevant supports*): pelvic fins / thoracic fins / headrest / pelvic belt / pommel / moulded seating system / harness / other

☐ Other _____

7. Transfer ability: (tick appropriate box)

☐ I can transfer on and off my chair / wheelchair without hands on assistance

☐ I can transfer on and off my chair / wheelchair with a small to moderate amount of assistance

☐ I require full assistance to transfer on and off my chair / wheelchair

☐ I can transfer myself on and off my wheelchair / chair if the environment is set up correctly for me

8. Wears AFO's (Ankle Foot Orthosis): Yes / No If yes, please bring to the appointment.

9. Recent Botox/ Awaiting Botox: Yes / No If yes, please provide detail?

10. Recent surgery/ Awaiting Surgery: Yes / No. If yes, please provide detail:

11. Please describe any significant restrictions to joint range of movement.

12. Practicalities

Has your therapist agreed that bike riding is a suitable activity for you? Yes / No

Have you got identified a safe place to ride your bike? Yes / No

Example(s):_____

Have you got someone to supervise your bike riding at all times? Yes / No

13. The information collected by Solve Disability Solutions is for the purposes of processing your enquiry, request, registration, donation and/or for promotional purposes. Solve Disability Solutions discloses personal and sensitive information to the volunteer/employee involved in the provision of the service you have requested. If you are giving personal information about another person, e.g. next of kin, you should seek their permission beforehand and advise why you are disclosing their details to Solve Disability Solutions. For a copy of our Privacy Policy visit www.solve.org.au or telephone 1300 663 243 or (03) 9853 8655.

14. I give permission:

- for my details to be entered in the Solve Disability Solutions database and be given to a volunteer to build the requested project. ☐ Yes ☐ No
- to be contacted for other Solve Disability Solutions purposes as mentioned in the Privacy statement above. ☐ Yes ☐ No

SIGNATURE: _____ PRINT NAME: _____

Date: _____/_____/_____

Funding Source for Bicycle: *Please provide NDIS details or funding body (if known)*

Other funding body / Plan Manager: _____

Contact Person: _____

Address: _____

_____ Postcode: _____

E-mail: _____ Phone: Wk: _____ Mobile: _____

If Client is an NDIS Participant please provide the following details

NDIS Client Number: _____ Plan Start Date: ____ /____ /____ Plan End Date: ____ /____ /____

☐ Payment by NDIS through PRODA Portal. *

☐ Payment by Participant (self-funded or self-managed NDIS participant).

☐ Payment by Plan Manager _____ *

(Name of Plan Manager)