# MEDICAL QUESTIONAIRE – SCOOTER

To be completed by a medical practitioner

EnableNSW provides scooters through the Equipment Allocation Program (EAP). The Medical Questionnaire and a Stock Equipment Request Form (SERF) completed by a community occupational therapist or physiotherapist, is required for all applications.

## 1. PERSONAL INFORMATION

| | | | |
|---|---|---|---|
| Name | Last Name<br>First Name | Address<br>Suburb & Post Code | |
| **Title** | ☐ **Mr** ☐ **Mrs** ☐ **Ms** ☐ **Miss** ☐ **Other** | **Date of birth:** | |
| **Phone** | | **Mobile** | |
| **Diagnosis** (relevant to request for scooter): | | **Other relevant medical/health conditions:** | |

## 2. PHYSICAL STATUS

a) Describe impact of diagnosis or health conditions on person's ability to walk

_____

(b) Visual Acuity: Right _____ Left _____

| Visual conditions: *Please respond to **all** below* | Yes | No |
|---|---|---|
| Glasses / contact lenses are worn to correct visual difficulties | | |
| Abnormal field of vision | | |
| Double vision | | |
| Poor night vision | | |
| Progressive eye condition | | |
| Other, please state | | |

## 3. SAFE USAGE

a) Does the person have any of the following medical conditions that require further investigation, and/or may impact their ability to use a scooter?

| Medical Condition: *Please respond to **all** below* | Yes | No |
|---|---|---|
| Diabetes | | |
| Epilepsy | | |
| Giddiness | | |
| Blackouts | | |
| Fainting | | |
| Sudden episodes of unconsciousness | | |
| Other, please state | | |

If yes please provide details. _____

(b) Mobility scooters are used in shared environments with motor vehicles.
Are you aware of any medical conditions that would preclude the person from holding a driver's license?
Yes ☐ No ☐

If yes, please provide details _____

Are you aware of any history of near misses or car accidents?
Yes ☐ No ☐

If yes, please provide details _____

## 4. PROGNOSIS

(a) In your opinion is the person's cognitive, visual and/or physical status likely to change in 2 years and affect his/ her ability to safely use a scooter? Yes ☐ No ☐

If yes, please provide details _____

(b) Will the use of a scooter impact negatively on the person's health or fitness level?
Yes ☐ No ☐

If yes, please provide details _____

_____

## 6. ADDITIONAL COMMENTS

Please provide any additional comments that you think may be relevant to the use of scooter.

_____

_____

## 7. DECLARATION

I declare that I have reviewed the questionnaire with my patient and:

☐ I do not have concerns about their ability to safely use a scooter. Further assessment by a suitably qualified prescriber is required to determine whether a scooter would best meet their mobility needs.
☐ I have concerns about their ability to safely use a scooter in the community.

| | |
|---|---|
| **Name of Medical Practitioner:**_____<br>**Name of practice:**_____<br>**Address:** _____<br>_____<br>**Phone:**_____<br>**Email:** _____ | **Provider number:**<br>**Days / hours available:**<br>**Signature and Date:** |