QEF Mobility Services 1 Metcalfe Avenue, Carshalton Surrey, SM5 4AW Tel: 020 87701151 Fax: 020 8770 1211 Email: mobility@qef.org.uk www.qef.org.uk



Please fill in all boxes on the application form.

We need this information to provide you with our services, and although data may be shared for healthcare purposes, vital interests, legal reasons or public interest, it will not be shared for marketing purposes without your explicit consent. For more detailed information on how we process your data and keep it secure, you can visit our website at https://www.qef.org.uk/privacy/ or contact the office by email or phone.

TRANSFER & SEATING ASSESSMENT

(Vehicle specifications, transferring in and out, safety and posture for travelling,

loading equipment and travelling in a wheelchair.)

For office use only:			
PERSONAL INFORMATION			
TITLE: SURNAME:	FC	DRENAME:	
DATE OF BIRTH: / /	EN	AIL:	
ADDRESS:	Со	ntact Tel (1):	
POSTCODE:	Cor	ntact Tel (2):	
If we have to call you and you are not available may we leave a message? YES/NO		YES/NO	
What is the nature of your disability/medical	condition?		
Please give brief details:			
Date of onset:	Do you experience any pain? YES/NO		YES/NO
Do you use a hoist? YES/NO If YES, pleas	e give details		
Are you in receipt of the higher rate mobility component of the Disability Living Allowance YES/NO or the enhanced rate of the mobility component of Personal Independence Payment?			
Have you been assessed by this Mobility Centre before? If YES , what year? Please give details?			
If NO , how did you hear of us?			

Are there any specific products you would like to see during your assessment? Please state model details and explain why.

A: ABOUT YOUR CIRCUMSTANCES

1. What do you hope to gain from your assessment?

2. Do you currently have any mobility equipment e.g. walking frame or wheelchair which you wish to take in the vehicle with you? Please provide details of weight, make, model and dimensions.

3. How do you currently get around indoors?

4. How do you currently get around outdoors?

5. What is the make an	nd model of your current	vehicle?	
a) Make:	b) Model:		c) Estate/Hatchback (please delete)
6. Does it have any ada	aptations? YES/N	10	
Please list:			
1			
7. Are you planning to	change your car? YES/I	0	
8. So that we can advis	se you, please let us knov	how any new ve	hicle will be financed (please circle):
Motability Privat	e purchase Company	car Other	
	e parenase company		
9. Plazca lat us know if	you will be using the ren	ort to provide inf	ormation to any third party. If so,
please give details:	you will be using the rep		
please give details.			

AB	ABOUT YOU OR THE PERSON WHO NEEDS THE ASSESSMENT		
1		nat is your weight:	
	Please describe how your condition affects you:		
2	Where do you park your car? (please circle) Garage Driveway On-road If Other (please d	escribe):	
3	Are there other factors that we should be aware of impairment? Please describe:	e.g. pain, fatigue, hearing or visual	YES/ NO
4	Can you stand from sitting independently? (please YES NO Only with assistance (*) (*) please give details	circle) Only with equipment (*)	
5	Do you have difficulty getting in or out of a car? If yes, please give details: YES/ N		YES/ NO
6.	Please add anything else you think we ought to kn	ow:	
Ger	eral Practitioner/Consultant:	Address:	
Tele	ephone:	Postcode:	

DECLARATIONS

I understand that the assessment may involve some manual handling application to en- able me to access any relevant equipment, such as the static rig unit or into a car.	YES/NO
I understand I have the right to withdraw from the assessment at any time.	YES/NO
I understand that there will be a 25% administration charge for all cancellations if another appointment is not required.	YES/NO
I understand that if I fail to attend my appointment, or do not complete the assessment or if I do not give at least 7 days cancellation notice, the fee will not be refunded.	YES/NO
I understand that staff may record images during assessments to provide additional content to the written report.	YES/NO
I give consent for this assessment to be carried out.	YES/NO
I give consent for QEF Mobility Services to contact my Doctor, if considered necessary, for any further medical information relevant to this assessment, which will be treated in strict confidence.	YES/NO
I give consent for a copy of the report to be sent to my Doctor by QEF Mobility Services. Signed	YES/NO

OFFICE USE ONLY Amount paid: £..... REF:....

Cost of Transfer & Seating assessment: £220.00

If you are over the age of 13 and do not have the above, and you would like a 3rd party to act or speak on your behalf, please complete details below:

Individual 1

Name:	Relationship to client:
Address:	
	Postcode
Mobile:	.Email:

Please indicate when you would like QEF to contact the person named above:-

To make appointments on my behalf	YES 🗆	NO □
To discuss progress, recommendations and outcomes	YES 🗆	NO □
To make payments	YES 🗆	NO 🗆

Individual 2

Name:	
Address:	
	Postcode
Mobile:	Email:

Please indicate when you would like QEF to contact the	e person nameo	d above:-
To make appointments on my behalf	YES 🗆	NO 🗆
To discuss progress, recommendations and outcomes	YES 🗆	NO 🗆
To make payments	YES 🗆	NO 🗆

If you want to change your decision at any time in the future, please let us know in writing.

Client signed Date Date

EQUAL OPPORTUNITIES DATA

We are obliged to ask this information from the organisations that fund our service.

You do not have to answer these questions, and if you choose not to, this will not make any difference to the service you receive. This section of the application form will be detached and the information collected will only be used for monitoring purposes in an anonymised format.

Ethnic Origin:
Asian Bangladeshi () Asian Indian () Asian Other () Asian Pakistani ()
Black African () Black Caribbean () Black Other () Chinese ()
Mixed Other () Mixed White + Asian () Mixed White + Black African
Mixed () Mixed White + Black Caribbean ()
White British () White Irish () White Other ()
Ethnic Other () Please specify
Declined to comment ()