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Evaluation Form

Therapist's Name: _____ Email _____
Phone# _____ Fax# _____
Mailing Address: _____
City, State, Zip: _____
Therapist Diagnosis: _____
Expected Growth Rate: _____
Passenger's Name: _____ Family Name: _____

Modifications & Custom Work For A Better Fit

"Please answer the following questions so we can assist you with the best fit"

Please Circle Answer

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- 1. Back Brace? Yes or No
- 2. Spinal Rod? Yes or No
- 3. Head Halo? Yes or No
- 4. Head Control? Yes or No

- 5. Torso Control? Yes or No
- 6. Limb Control? Yes or No
- 7. Wind Swept Legs? Yes or No
- 8. Seizures? Yes or No

Therapist or Seating Specialist – Please make your recommendations

Mobility Push Chairs	Color	Model#	Quantity
Axiom 1.5	Red	16" IOM-1.5-09R	
Axiom 1.5	Navy	16" IOM-1.5-09N	
Axiom 2	Red	16" IOM-2-04R	
Axiom 2	Navy	16" IOM-2-04N	
Axiom 3	Red	16" IOM-3-04R	
Axiom 3	Navy	16" IOM-3-04N	

Accessories	Color	Model#	Quantity
Bug Canopy All Sizes	Mesh	ASC-SB2-040	
Sheerling Insert All Sizes	Natural	ASI-DB-040	
Flashing Light	Red	AFL-04R	
Bunting Bag All Sizes	Silver	ABB-07R	

We strive to provide the best fit for the passenger. If you have a special request please let us know. We often can make modifications at an additional cost. _____

At Adaptive Star we believe in Going Out & Making A Difference, we hope you will join us on our journey.