Clinician standing questionnaire

Medical clearance is required before attempting to stand in Permobil power standing products.

Name:	
Height:	**Weight:**
Diagnosis/medical history:	
Therapist's name/title:	
Hospital/clinic:	**Date of request:**
Phone #:	**Email:**

Preliminary standing information

Does client currently stand (with or without equipment)? ☐ Yes ☐ No

Current standing equipment, please describe:

Transfer status:

Frequency of standing? ☐ *≤ 1–2x daily* ☐ *≤ 1–2x weekly* ☐ *≤ 1–2x monthly* ☐ *≤ 1x month* *Other:* _____

Duration of standing per session:

When was the last time client stood?

Any range of motion limitations? ☐ Yes ☐ No

If yes, please describe:

Bone density status:

History of fractures, please describe:

Does client experience orthostatic/postural hypotension? ☐ Yes ☐ No

Any additional relevant medical history or safety concerns?

The information collected on this form is intended to enhance communication between the health care professional and authorized Permobil provider as it relates to the provision of a standing power wheelchair. This form is intended to be used as a template only and will not be collected or retained by Permobil. If you have any questions about how Permobil uses personal data, including protected health information, please visit privacy.permobil.com.