MEDICAL QUESTIONAIRE – SCOOTER

To be completed by a medical practitioner

HealthShare
EnableNSW

As mobility scooters are used in community settings and public thoroughfares, safe usage is important. The application process for requesting a mobility scooter through EnableNSW requires the completion of this medical questionnaire to ensure that there are no medical, physical, visual, cognitive or other conditions that would affect ability to use the scooter safely.

In addition to this questionnaire, an assessment and completed scooter equipment request form is required from an eligible prescriber, usually a community occupational therapist or physiotherapist.

1. PERSONAL INFORMATION

Name	**Last Name** **First Name**	**Address** **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

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(b) Visual Acuity: Right ________ Left ____________

Visual conditions *tick all that apply*	Yes	No
Are glasses / contact lenses worn to correct visual difficulties?		
Abnormal field of vision		
Double vision		
Poor night vision		
Progressive eye conditions		
Other, please state		

3. SAFE USAGE

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

Medical Condition *tick all that apply*	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 a 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 ____

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6. ADDITIONAL COMMENTS

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

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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:____________________	**Provider number:**

Name of practice:______________________________ **Address:** _____________________________________ ____ **Phone:**_______________________________________ **Email:** _______________________________________	**Days / hours available:**
	Signature and Date: