ADULT WHEELCHAIR REQUEST FORM

International Wellness Foundation
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Website: www.international-wellness-foundation.com
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HOW THIS FORM WORKS This form must be completed for adult patients with a permanent disability.

Sections A and B should be fully completed by the recipient. Section C **must** be signed by **a registered healthcare professional.**

SECTION A

Applicant Name:	**Date of birth:**

Address: adres

Telephone:	**Education/Profession:**

Delivery Address (if different)

SECTION B

Main diagnosis/disability:

Other significant diagnoses or disabilities:

Patients: HEIGHT	**WEIGHT**

SECTION C

HEALTHCARE CONTACTS: please indicate who filled in the form

HOSPITAL DOCTOR ☐ GENERAL PRACTITIONER ☐ PHYSIO ☐
THERAPIST (O/T) ☐ OTHER (state)……..

This section must be completed / signed by a registered healthcare professional

Name:	**Telephone:**
Address:	
Signature:	**Date:**