Office use only	#	Date approved:

The details of Child:

Name:
DOB
Medical Condition:

Please tick which of the following apply (One per row):

Physical ability:				
Has some walking ability but this is not functional or effective due to difficulties with balance, strength, coordination, endurance or other impairment	Not yet walking due to delayed milestones but expected to walk <u>independently</u> in the future e.g. Cerebral palsy (**GMFCS I-II**), hypotonia , ill health impacting on gross motor development, global delay	Not yet walking but expected to have some <u>assisted</u> walking ability in the future e.g. cerebral palsy (**GMFCS III**), low level spina bifida, SMA type III etc.	Expected to have none or very limited walking ability e.g. cerebral palsy (**GMFCS IV-V**), SMA II, arthrogryposis, SCI, higher level spina bifida etc.	
Dynamic Sitting				
No	With significant support	With moderate support	With minimal support	Independently
Standing				
No	With significant support	With moderate support	With minimal support	Independently
Postural support needed in sitting				
Sits independently without needing support **(Chailey level 6-7)**	Sits fairly well but needs support for safety **(Chailey level 4-5)**	Head control is fair to good but unable to sit without support **(Chailey level 2-3)**	Needs head and body supported in sitting position **(Chailey level 1)**	
Head control:				
Needs full support	Needs some supports	Intermittent	Will need support when driving	Well established
Hand Function for driving:				
Adapted steering wheel	Standard steering wheel	Buddy Buttons	Head Switch	
Highest level of floor Mobility:				
Rolling	Scooting	Crawling	Supported Walking	Independent Walking
Cognitive ability				
Limited ability to understand and interact with	Limited ability to understand and follow instructions	Easily understands and can follow instructions. Interested in other people and the external environment.		

external environments		
Power ability		
Already has powered mobility device and uses it most of the time	Is in the process of getting a power mobility device or still learning to use one	Is not expected to get a powered mobility device in the next year or more.

Will Postural Support be required for safety during driving:	Yes	No

Therapist's availability for involvement **(please circle)**	Initial Fitting GBG Therapist Conversation Ongoing follow up
	Preferred contact: email / phone **Best day/time to phone**:

Diagnosis: ***Please list all health and disability diagnoses here***

List any orthotics used:

Current functional goals / Goals you would like to address with GoBabyGo:

1.

2.

3.

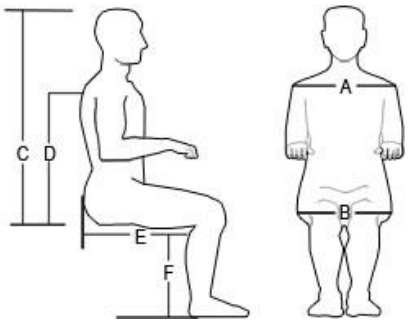
Mobility equipment history / experience:

Current weight:

Measurements required:

Overall height

	Measurement (cm)
A – Shoulder width	
B – Hip Width	
C – Seat to Top of Head	
D – Seat to Shoulder	
E – Seat to Inside of Knee	
F – Back of Knee to Back of Heel	



Any worries or queries, please contact me on

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