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| **POSTURAL MANAGEMENT (LYING) ADVISORY SERVICE REFERRAL**  **This service is available for EMS assessors in the Waikato, BOP & Lakes regions.**  Please send your referrals to:  P O Box 5725, Frankton, Hamilton ⚫ Ph 07 848 1825 ⚫ Fax 07 848 1439 ⚫ Email: hamilton@seatingtogo.co.nz | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please contact the Seating To Go General & Training Manager if you have any queries.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Therapist Information:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | | |  | | | | | | | |  |  | | | | | | | | | | | | | | | | **Ph:** | | |  | | | | | | | | | | | | **Mob:** | | | | | |  | | | | |
|  | | *(first)* | | |  | | | | | | | *(Surname)* | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Work Address:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | **Email:** | | |  | | | | | | | | | | | | | | | | | | | |
| **Employed by:** | | | | |  | | | | **MOH Provider** | | | | | |  | | **MOE** | | | | | |  | | | | **Specialist School** | | | | | | | |  | | | | | | | **Private** | | | | | | | | | | | |
| **Area:** | | | | |  | | | | **Waikato** | | | | | |  | | **BOP** | | | | | |  | | | | **Lakes** | | | | | | | |  | | |  | | | | | | | | | | | | | | | |
| **Indicate area of credential if applicable:** | | | | | | | | | | | | | | | |  | | **Level 1 WMPM** | | | | | | | | | | | |  | | | **Lying** | | | | | | | |  | | | | | **Level 2 WMPM** | | | | | | | |
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| **Client Related Information:** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Name:** | | | |  | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | | | | | | | | | | | |  | | |  | | |
|  | | | | | *(first)* | | | | | | |  | | | | | | | | | | | | | | *(Surname)* | | | | | | | | | | | | | | | | | | | | | | | | *(Title)* | | | |
| **Date of Birth:** | | | | |  | | | | | | | | **NHI No:** | | | | | |  | | | | | | | | | | | | |  | | | | | **Male** | | | | | | |  | | | | **Female** | | | |
| **Address:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | |
| **Phone Number: (Hm)** | | | | | | | |  | | | | | | | | | | | | | **(Wk)** | | |  | | | | | | | | | | | | | | | **(Mob)** | | | | | |  | | | | | |  | | |
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| **Complete all sections (please print clearly)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Advice required:** | | | | | | | | | | | | | | | | | | | | | | | | | **Current Level of Mobility:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Joint assessment | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Advice on equipment/trial set up | | | | | | | | | | | | | | | | | | | | | | | |
|  | Other (specify below) | | | | | | | | | | | | | | | | | | | | | | | |
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| **Disability / Health Issues:** | | | | | | | | | | | | | | | | | | | | | | | | | **Describe Current Positioning Equipment:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Diagnosis if known) | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Additional relevant Information:** Please attach any assessments of photographs that may assist with planning. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Therapist Signature:** | | | | | | |  | | |  | | | | | | | | | | | | | | | | | | |  | | **Date:** | | | | |  | | | |  | | | | | | | | | | | | | |