INNOVA®
CARE CONCEPTS

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TRIAL REQUEST FORM

Please complete all fields that apply.

Client Name: _____

Client Address: _____

Client Email: _____ Client Contact Phone: _____

Client Age: _____ Client Date of Birth: _____

Medical Condition: _____

Parent/Carer Name: _____

Parent/Carer Email: _____ Parent/Carer Phone: _____

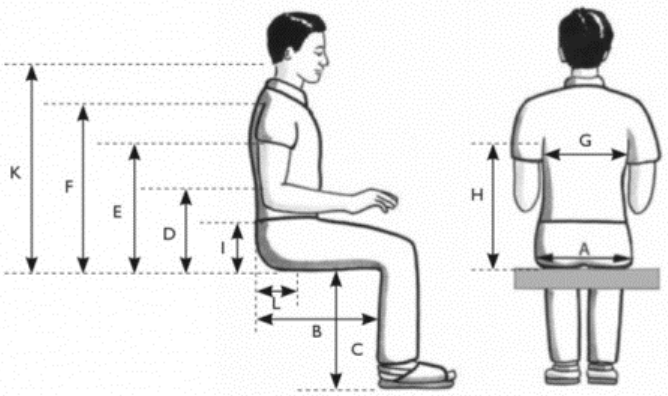
OT: _____ OT Organisation: _____

OT Phone: _____ OT Email: _____

Client Measurements -

Please complete all fields that apply.

A	**Hip Width**	cm
B	**Seat Depth *(back pelvis to back knee)***	cm
C	**Calf Length**	cm
D	**Seat Bottom to Rib Cage**	cm
E	**Seat Bottom to Shoulder Blade**	cm
F	**Seat to the Top of Shoulder**	cm
G	**Trunk Width**	cm
H	**Seat to the Axilla Armpit *(adjust according to hand stimulation)***	cm
I	**Seat to the Top of the Pelvis (PSIS)**	cm
J	**Distance Between Knees *(width of knee separator pad)***	cm
K	**Seat to Base of Skull**	cm
L	**Back of the Pelvis to Seat Bones**	cm



User Or Auto-Attendant Controls:
If User what Side of The Chair?

Details to Note –

Include issues with current provision, possible support required for optimum seating & any other possible postural support requirements.

Consent to use images of client using product/s: