REFERRAL - QUESTIONNAIRE FOR GoBabyGo APPALACHIA

Participants Last Name:_____ First:_____ MI: ____

Birthdate: _____ Parent/Legal Guardian:_____

Address: _____ Apt #:_____ County: _____

City: _____ State:_____ Zip:_____ Home Phone#: _____

E-mail: _____ Mobile #: _____

1. Can the child sit (Independently)?_____
2. How much assistance does the child need to sit and where is the assistance required? (head, trunk, pelvis…)

3. Does the child have any assistive technology he/she is currently using?

   _____
4. Does the child respond to his/her name?_____
5. Does the child understand a cause and effect relationship (if you say No does he/she stop)?_____
6. Is the family currently able to make a time commitment to this project? _____
7. Can the child use an adaptive switch using their head, trunk, arm or leg?

   _____
8. Does the family have space to use the car and a dry area to store it ? _____
9. Why does the family want this for their child?

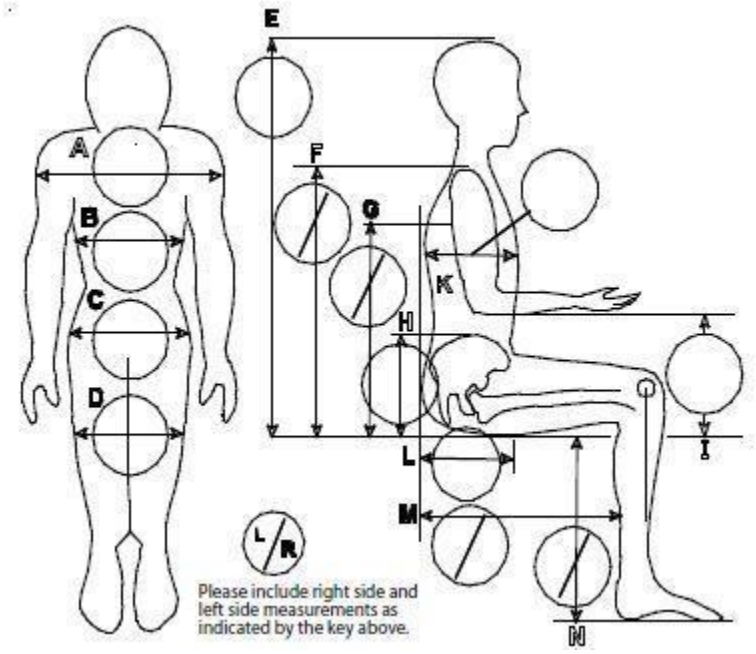
AdaptoPlay
Because Play Matters

mobility & sociability
GO BABY go!
APPALACHIA

SEATING & MOBILITY EVALUATION

CHILD'S NAME : _____

DATE OF ASSESSMENT : _____



Top of Head (E) =_____

Top of Shoulder (F) =_____

Axilla height (G) =_____

Chest depth (K) =_____

Thigh length (M) =_____

Thigh to floor (N) =_____

Chest width (B) =_____

Hip Width (C) =_____

Weight =_____

Physical/Occupational Therapist input

PT/OT Name : _____ Contact #:_____

Contact Email:_____

Current Seating System: _____

Child will likely require... (Check all that apply):

- ☐ Modified steering wheel
- ☐Multi-switch steering
- ☐Joy-Stick steering
- ☐Indoor Vehicle
- ☐Bumbo Scoot (Manual w/c)
- ☐Anterior trunk support
- ☐Lateral trunk support
- ☐Head / Neck support
- ☐Padded Seat
- ☐Outdoor Vehicle Other (Special requests/instructions; Please attach)

Any other information from Therapist?