

TheraSuit™ & TheraSuit Method™ PPR Consent Form

All sections **must** be completed and the form **signed** by the parent/guardian of the participant unless participant is over 19 years.

Personal Information of Participant

Name: Male / Female

Date of Birth: Age:

Address:
.....

Emergency Contact Name: Relationship:

Address:
.....

Emergency Contact Tel No:

Diagnostic Criteria

a) Primary Diagnosis

Details:

b) Date of Primary Diagnosis?

Cause:

c) Secondary Diagnosis/es

Details:



Medial History

a) History of Fractures

Details:

b) Epilepsy

Details:

[please complete epilepsy protocol]

c) Allergies / Contra Indications

Details:

[please complete allergies protocol]

d) Significant Surgeries / Medical Emergencies

Details:

e) Relevant History

Details:

f) Safe Swallow

Details:

MEDICATIONS

NAME	DOSAGE	DETAILS
NAME	DOSAGE	DETAILS
NAME	DOSAGE	DETAILS
NAME	DOSAGE	DETAILS

MEDICAL EQUIPMENT

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THERAPY EQUIPMENT

ORTHOTICS	
WALKER	
CANES / STICKS/ TRIPODS	
WHEELCHAIR [INDOOR] WHEELCHAIR [OUTDOOR]	
SEATING	

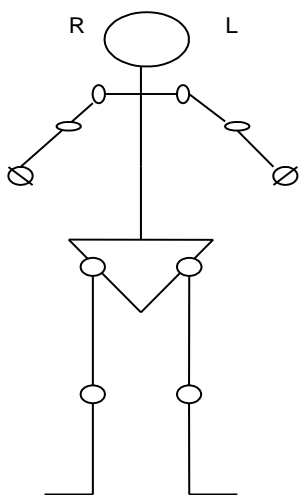


BODY MEASUREMENTS AS A GUIDE TO PRESCRIPTION OF THERASUIT – in cm

HEIGHT:	cm	INCHES
WEIGHT:	Kg	lbs.

Circumference of CHEST	cm	INCHES
Circumference of WAIST	cm	INCHES
Circumference of THIGH	cm	INCHES

SKIN INTEGRITY [MARK AREAS OF PRESSURE]



SPECIFIC MEASUREMENTS

A Width of hips	cm
B Hip to knee (popliteal crease)	cm
C Back of knee (popliteal crease) to floor	cm
D Seat to elbow	cm
E Seat to shoulder	cm
F Seat to head	cm
G Width of shoulders	cm



PREVIOUS THERAPIES

DETAILS	WHEN	WHERE
DETAILS	WHEN	WHERE
DETAILS	WHEN	WHERE
DETAILS	WHEN	WHERE

MEDICAL INVESTIGATIONS / REPORTS

X RAYS	DATE / WHERE	DETAILS
MRI	DATE / WHERE	DETAILS
EMG	DATE / WHERE	DETAILS
	DATE / WHERE	DETAILS
	DATE / WHERE	DETAILS



PROFESSIONAL TEAM INVOLVED

NEUROLOGIST	LAST SEEN / DATE / WHERE	DETAILS
PAEDIATRICIAN	LAST SEEN / DATE / WHERE	DETAILS
ORTHOPAEDICS	LAST SEEN / DATE / WHERE	DETAILS
PHYSIOTHERAPIST	FREQUENCY	DETAILS
OCCUPATIONAL THERAPIST	FREQUENCY	DETAILS
SPEECH & LANGUAGE THERAPIST	FREQUENCY	DETAILS
NURSING	FREQUENCY	DETAILS
DIETETICS	FREQUENCY	DETAILS
		DETAILS
		DETAILS



MOVING & HANDLING / RISKS

EQUIPMENT	PROCEDURE	RISKS
EQUIPMENT	PROCEDURE	RISKS

INFORMED CONSENT TO TREAT

<input type="checkbox"/>	PPR [signature / print name]	date
<input type="checkbox"/>	PPR [signature / print name]	date
<input type="checkbox"/>	THERAPIST [1] [signature / print name]	date
<input type="checkbox"/>	THERAPIST [2] [signature / print name]	date

