

# HEALTH PROFESSIONAL DOCUMENTATION FOR SERU APPLICATIONS

Date:  |  |

Student Name: \_\_\_\_\_ DOB:  |  |

Diagnosis: \_\_\_\_\_

Preschool/School: \_\_\_\_\_

Principal: \_\_\_\_\_ Teacher: \_\_\_\_\_

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Health Professional: \_\_\_\_\_

Organisation: \_\_\_\_\_

PT / OT / SP / Medical (please circle)

Contact Number: \_\_\_\_\_ Best days to contact: \_\_\_\_\_

Email: \_\_\_\_\_

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Reason for request of equipment:

Student's current performance and needs / background information:

(eg mobility and postural skills, level of independence, current equipment use)

Equipment requested:

Model:  
Size:  
Specification / accessories required:

Additional information attached

Is item requested to replace existing SERU equipment?

Yes	No
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## PURPOSE OF EQUIPMENT

<b>Student's Needs (physical status)</b>	
<b>Access to Curriculum</b>	
<b>OHS Considerations</b>	
<b>Personal Care</b>	
<b>Other</b>	

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<b>Other equipment that has been tried for this purpose</b>	<b>Suitability</b>

\_\_\_\_\_  
Therapist: