Measuring Worksheet

Please print or type: Application # ____

Applicant's Name ______________________________
Last First Middle

Street Address ______________________________

City ______________ State/Province __________ Postal __________ Country ________

Contact Phone # ______________ Fax # ______________ Email ______________

Date of Birth ____________ Age ________ Sex ________ Height __________ Weight __________
day/month/year Indicate inches or cm Indicate pounds or kg

Type of mobility requested? ______________________________

Can you sit without support? Y N Can you hold your head without support? Y N

Can you talk to us? Y N Can you self-propel? Y N

Patient's Measurements

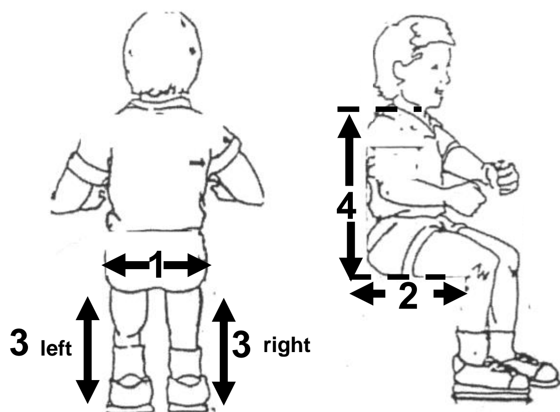
(See Diagram Below) cm___ inch___

1) **Hip Width** ________

2) **Seat Depth** ________

3) **Foot Drop left ___ right___**

4) **Top of Shoulders to Seat** ________



Before picture

After picture

What type of wheelchair would you suggest?

____

Person filling out form

____

Office Info. Only:

PO Box 11765
Bozeman, MT 59719

info@rocwheels.org

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Conversion Chart

Inch:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**
Cm :	**2.5**	**5**	**7.6**	**10.2**	**12.8**	**15.2**	**17.8**	**20.3**	**22.9**	**25.4**	**28**	**30.5**	**33**	**35.6**	**38.1**	**40.6**	**43.1**	**45.8**	**48.3**	**50.8**	**53.3**