Care & Independence

Glove™ Sling

REMOTE GLOVE SLING™ ASSESSMENT FORM
APPLIES TO: Deluxe, In-Chair, and Convenience models only

To be completed by the Assessor. Please tick all appropriate responses and provide detail where requested.

1. **Does the Service User (SU) currently use a GLOVE SLING™?**
   ☐No ☐Yes: Sling model:.. Serial No:...
2. **What's the SU height (head to heel) and girth (circumference)?** *Please refer to sizing chart*
   Height:........................cm. Girth:......................... cm.
3. **What is the SU weight?**....................................Kgs.
4. **What function does the sling need to perform?**
   ☐InChair ☐Toileting ☐Bathing ☐Access ☐Other please specify...
5. **Does the SU require head support?** ☐Yes ☐No
6. **Are they an above knee amputee?** ☐Yes ☐No
7. **Does the user suffer extensor spasm or have excessive movements?** ☐Yes ☐No
8. **Is a chest band required?** ☐Yes ☐No
9. **What position does the SU need to achieve or what position are they able to maintain?**
   ☐Seated ☐Supine ☐Reclined
10. **What type of hoist /spreader bar is in use?**
    ☐Clip ☐Loop ☐Wide ☐Narrow ☐Otherplease specify...
11. **Is there a profiling bed?** ☐Yes ☐No
12. **Wheelchair/ Seating arrangements:**...
    ....
    ....
13. **Please detail what type of wheelchair or armchair is in use:** ....
    ....
    ....
14. **Can a sling be applied and removed easily?** ☐Yes ☐No
15. **Does the chair have any of the following that may make it difficult to apply a sling?**
    ☐Lap belts ☐Pelvic straps ☐Harnesses
16. **What equipment does the SU use when bathing, showering or toileting?**
    ☐Tilt-in-Space Chair ☐Tilt-in-Space Cradle ☐Shower commode ☐Trolley
    ☐Stretcher ☐none ☐other Please specify:...

Additional notes:

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