Go Baby Go Powered Mobility Program Application

Child's Name: ______________________ DOB: ______________

Primary Diagnosis: ______________________

Child's Weight: ______________ Child's Height: ______________

Parent(s) Full Name: ______________________

Address: ______________________ City/State/Zip: ______________

Phone: (Home) __________ (Cell) __________ Email: __________

Referring Therapist's Name: ______________________

Therapist's Phone: ______________Therapist's Email:______________

VEHICLE TYPE REQUEST	VALUE
☐ 6 V Small Car	$225.00
☐ 6 V Medium Car	$300.00
☐ 6 V Large Car	$450.00
☐ Other:______________	TBD

SEATING SUPPORT NEEDED

- ☐ Side Rail Support
- ☐ Back/Head Support
- ☐ Chest Harness
- ☐ Seat Belt
- ☐ Other additional supports (please describe)______________

Switch Type: ______________ Switch Placement: ______________

Notes: *(e.g. Will gooseneck be needed?)* ______________________

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Please check all additional items needed for car adaptation. (Some options are not available on all cars.)

- ☐ Speed control
- ☐ Interval timer
- ☐ Remote control *(Not available on most cars)*
- ☐ Parent steering *(Not available on most cars)*
- ☐ Other______________________