DOCTOR'S MEDICAL CERTIFICATE

RE: Recommendation for use of prescribed restraint

Client's full name:	Date of birth:
Client's Diagnosis:	
Parent/Carer full name:	Telephone:
Address:	

This letter certifies that _______________ (client name) has been diagnosed with the permanent disability of _______________.

As a result, he/she is unable to travel in his/her standard vehicle seat, and requires _________ (the restraint you are applying for) for use in his family/personal vehicle when travelling.

I recommend that the ____________ (restraint name) is used by _______ (client name) to provide _____________________ (whatever it is helping with i.e. posture, behaviour, safety etc) during travel.

Please refer to advice to parents form from prescriber, ___________ (Occupational Therapist).

Doctor's Signature:	Stamp (if applicable):
Doctor's name:	Date:
Doctor's Contact details (email/phone):	