

AMTRYKE® ASSESSMENT FORM (MUST BE FILLED OUT COMPLETELY BY THERAPIST)

Request form, assessment form, and liability waiver are required for tryke Placement

Child's Name: _____

Ship To: _____ Attn: _____

City/State/Zip _____ Phone #: _____

Age: _____ Weight: _____ Height: _____

Special Consideration, i.e.: Leg length discrepancy, etc.

Desired Goal or Outcome:

Arm Length and Leg Length Measurements are Critical to Correct AmTryke® therapeutic tricycle selection. Please Complete. Measurements in inches.

**Arm Length (shoulder to knuckles) Right: _____ Left: _____

**Leg Length (hip to bottom of shoe) Right: _____ Left: _____

AmTryke Model Requested: ____ Happy ____ Jumbo ____ AM-9 ____ AM-12 ____ AM-16 ____ 1402

Adaptive Equipment: Circle accessories needed. (visit www.ambucs.org, to view the products)

AM-9: SMALL or LARGE bucket seat Vertical Hand Grips Wrist Wraps XS, S, M, L, XL

Toddler Foot-cups Pedal Block (1 equals 1/2-inch) ____ Hand Wraps 1 or 2 Knee adductor strap

AM-12, AM-16, Seating Option: BUCKET SEAT or SADDLE SEAT/BACK REST

Push Bar Wrist Wraps XS, S, M, L, XL Hand Wraps 1 or 2 Bench Seat

1400 Seatback (includes push bar, back, 2 laterals) 1400 Head Rest 1400 Hip Pad

Pedal Block (1 equals 1/2-inch) ____ Medium or Large Foot-cups Knee separator

Knee adductor strap S M L

1402 ProSeries (includes saddle seat with 1400 Seatback-pushbar, back, 2 laterals)

Wrist Wraps XS, S, M, L, XL Hand Wraps 1 or 2 Bench Seat Bucket Seat

1400 Hip Pad 1400 Head Rest Knee separator Knee adductor strap S M L

Are you the treating therapist for this child? Yes or No Are you the therapist at the Demo Site? Yes or No

Therapist Name: _____

Demonstration Site Name: _____

(If not a Demo Site) Facility Name/Address: _____

Phone: _____ Email Address: _____

Therapist Comments Concerning Child: _____

Therapist Signature _____ Date _____

Please return a copy of this completed form to: AMBUCS™ Resource Center PO Box 5127 High Point, NC 27262

Phone Number: 888-AMTRYKE Fax Number: (336) 852-6830

AMTRYKE® THERAPEUTIC TRICYCLE WAIVER

PURPOSE The AmTryke® therapeutic tricycle was designed for children with disabilities. The hands, feet, or both power the tricycle. It allows freedom to travel, builds self-esteem, strengthens muscles, and improves motor coordination and range of motion while making exercise fun.

WISH LIST **To be eligible for the National Wish List all three forms must be received by the Resource Center. The three forms are the Request Form, Assessment Form, and Liability Waiver. Once these forms are received, the child's name is placed on the list and will remain there until the funds are raised to purchase the AmTryke® therapeutic tricycle for the child. This may take some time, please be patient.**

STEERING Initially, the child may have difficulty turning or changing directions. Encourage the child to go straight ahead, back up and slowly turn around.
There are three steering options for the AM-12 and AM-16 Models. There are two steering options for the AM-9 Models. All are shipped in the locked forward position. This is for shipping safety and also allows time for a new rider to build strength and control.

CAUTION

***Fast speeds and sharp turns can cause the AmTryke® therapeutic tricycle to tip or turn over!
Always wear helmet when riding AmTryke® therapeutic tricycle with adult supervision!***

AMBUCS™ members nationwide are dedicated to creating opportunities for mobility and independence for people with disabilities by performing community service, providing AmTryke® therapeutic tricycles to children with disabilities, and providing scholarships for therapists.

The information contained in this service is not intended nor implied by National AMBUCS™, Inc. to be professional medical advice by National AMBUCS™, Inc.. Always seek the advice of your physician, therapist or other qualified healthcare provider prior to starting any treatment or with any question you may have regarding a medical condition. Nothing contained in this service is intended by National AMBUCS™, Inc. to be for medical diagnosis or treatment by National AMBUCS™, Inc., or on behalf of National AMBUCS™, Inc.

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Child's Name: _____ **Phone:** _____

Address: _____

City/State/Zip: _____

Print Legal Guardian Name: _____

Legal Guardian Signature: _____ **Date:** _____

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<http://www.ambucs.org/>
<mailto:ambucs@ambucs.org>

