BOUNDLESS CYCLES INITIATIVE INTAKE FORM – VA Hospital

ADAPTIVE BIKE / ACCESSIBLE BIKE

Recipient's Name:_____ Recipient's Date of Birth:_____

Email Address: _____ Telephone Number: _____

Mailing Address: _____

Primary Diagnosis: _____

VA Hospital: _____ Rec Therapist Name: _____

Rec Therapist Email: _____ Rec Therapist Telephone: _____

What Equipment are you seeking? ___ Recumbent Trike ___ Recumbent Quad ___ Tandem ___ Hand Cycle

What County do you live in? _____ Any Other Funding? _____

How did you learn of Kids Mobility Network? _____

Please answer the folllowing questions:

Recipient's Height: _____ Recipient's Weight: _____ Recipient's inseam: _____ Inches

Has the recipient used an adaptive or accessible bike before? _____ What bike?_____

Please provide additional information about type of cycle you are seeking and the type of riding you are planning.

_____

_____

_____

_____

Submit completed form to info@kidsmobility.org

Questions? Contact Kids Mobility Network at 303-242-8281 or visit www.kidsmobility.org