SIT-STAND WORKSTATION CLINICAL RECOMMENDATION FORM

Personal Information

Your Name: _____

Profession: _____ Date: _____

Company: _____

Client Information

Client Name: _____

Injury / Condition Treating: _____

Treatment length: _____ Treatment frequency: _____

Current symptoms: _____

Current sitting tolerance: _____

Sit-Stand Desk Recommendation

Have you considered alternative measures such ergonomic seating/equipment, work techniques and assistive software to manage your client's symptoms at work? **Yes** ☐ **No** ☐

Previous recommendations:

_____

_____

Do you see there being any potential risks in implementing a sit-stand workstation e.g. aggravation of pre-existing injuries or medical conditions? **Yes** ☐ **No** ☐

_____

_____

Is a sit-stand workstation a physical requirement for your client to continue performing their role at UWA, considering the nature of their work and impact of medical condition: **Yes** ☐ **No** ☐

_____

_____

Please outline your clinical reasoning for implementing a sit-stand workstation for your clients injury / condition below:

_____

_____

_____

Expected outcomes of implementing a sit-stand workstation:

a. Impact on work capacity (hours, duties): _____

_____

b. Impact on symptoms: _____

_____

How frequently would you recommend alternating between sitting and standing?

_____

_____

UWA would typically recommend a height adjustable platform which is gas lift operated and estimated to require 3-5kg of manual force between shoulder and waist height.
Please indicate if a height adjustable platform is suitable for your client:

Yes ☐ **No** ☐

Any other comments or recommendations UWA should consider (e.g. low impact surfaces, footwear, alternative ergonomic equipment)?

_____

_____

Signature

Name: _____ Date: _____

Signed: _____