

HEIGHT ADJUSTABLE WORKSTATION RECOMMENDATION FORM

HEALTH CARE PROVIDER INFORMATION

Name: \_\_\_\_\_

Profession: \_\_\_\_\_

Company: \_\_\_\_\_

CLIENT INFORMATION

ECU Employee Name: \_\_\_\_\_

Discomfort/Injury treating: \_\_\_\_\_

Treatment length: \_\_\_\_\_

Treatment frequency: \_\_\_\_\_

Current symptoms: \_\_\_\_\_

Current sitting/standing tolerance: \_\_\_\_\_

Will the injury be ongoing (please circle)? Yes No  
If no, what is the anticipated recovery time period? \_\_\_\_\_

Please Note:

In addition to the above ECU’s Wellness Clinic is also situated at the Joondalup Campus and specialises in programs for people with existing chronic conditions. They can provide 5 free care plan sessions with a referral from a GP or alternatively self-referrals are \$10-19 per session depending on the level required. Their services include:

- Health screening and assessment of exercise and fitness levels.
- Help and development of self-management exercise strategies for chronic conditions.
- Educational training on healthy living.
- Supervised exercise programs tailored to meet individual needs.

ECU also provides a [Health and Wellness](#) program with regular wellness sessions on sleeping, nutrition, exercise, mental health and finances.

HEALTH CARE PROVIDER SIGNATURE

Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_