



# Stair Lift Site Assessment

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## Patient Information

Patient Name \_\_\_\_\_

St. Address \_\_\_\_\_

Contact \_\_\_\_\_

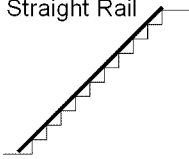
Town \_\_\_\_\_

Phone # \_\_\_\_\_

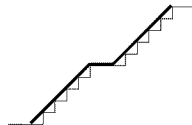
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Circle diagram best matches your staircase?

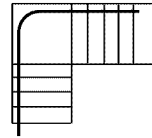
Straight Rail



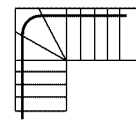
Intermediate landing



90° Flat



90° Short  
Radius Spiral



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What is the width of the staircase? \_\_\_\_\_ in.

Are there any obstructions in the staircase such as window sills or pillars? Yes No

Are there doorways directly at the top or bottom of the staircase? Yes No

Does the patient intend to use the lift without assistance? Yes No

Will the patient need the lift for less than 6 months? Yes No