

**Occupational Therapy**

**Furniture Height Chart**

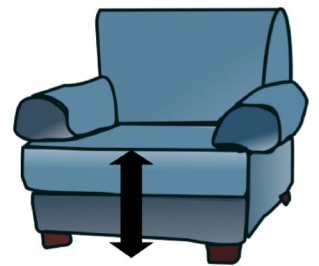
Patient's name.....

Hospital Number.....

**Please fill out the information below to ensure we can issue the correct equipment:**

**Chair**

- Depressed height of chair: **Whilst sitting on the chair**, what is the height from the floor to the top of the seat cushion? \_\_\_\_\_
- Describe the type of chair you sit on? (e.g armchair, sofa) \_\_\_\_\_
- Do you have any extra cushions on the seat of the chair? \_\_\_\_\_
- Has the chair already been raised? Yes / No  
If so, with what? \_\_\_\_\_



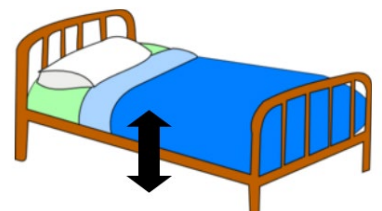
**Please tick which type of leg the CHAIR has ↓**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Block</b> 	<b>Block &amp; Castor</b> 	<b>Castor</b> 	<b>Leg&amp;castor</b> 	<b>Straight leg</b> 	<b>Curved leg</b> 
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please tick which type of leg the BED has ↑**

**Bed**

- Depressed height of bed: **Whilst sitting on the bed**, what is the height from the floor to the top of the mattress? \_\_\_\_\_
- Is it single / double / king size / other (please specify)? \_\_\_\_\_
- Is the base divan or slatted? \_\_\_\_\_
- How many legs / castors are there? \_\_\_\_\_
- If the bed has a castor; is it a ball or wheel? \_\_\_\_\_
- Any adaptations/ equipment? (e.g. electric profiling bed, raisers,

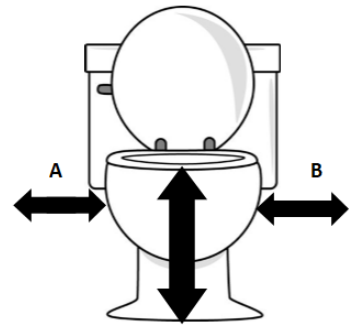


Please measure the height from the floor up to the top of the toilet:

**Toilets**

**Upstairs:**

- Height: With seat down: \_\_\_\_\_ With seat up: \_\_\_\_\_
- Are there any attachments?  
e.g. rails, raised seat/ raised seat with arms/frame around toilet \_\_\_\_\_
- What is the clearance around the toilet? A: \_\_\_\_\_ B: \_\_\_\_\_



**Downstairs:**

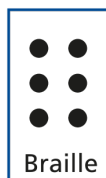
- Height: With seat down: \_\_\_\_\_ With seat up: \_\_\_\_\_
- Are there any attachments? e.g. rails, raised seat/ raised seat with arms/frame around toilet \_\_\_\_\_
- What is the clearance around the toilet? A: \_\_\_\_\_ B: \_\_\_\_\_

Is there any other relevant information about your toilet, e.g. square shaped toilet? \_\_\_\_\_  
 Do you have a commode? Yes / No If Yes, what height? \_\_\_\_\_

**Extra comments about home environment (i.e. internal steps, loose rugs, other hazards):**

**For a translation of this leaflet or for accessing this information in another format:**



Please contact (PALS) the Patient Advice and Liaison Service on:

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<b>Author</b>	Orthopaedic Team		<b>Department</b>	Occupational Therapy	
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**Legal Notice**

Please remember that this leaflet is intended as general information only. We aim to make the information as up to date and accurate as possible. Please therefore always check specific advice or any concerns you may have with your doctor.

