

Functional Mobility & Wheelchair Assessment ©

PATIENT INFORMATION:

Name:		DOB: / /	Sex: M / F	Date: / /	Time:
Address:		Physician:		<i>The following ATP was present and participated in this evaluation</i> _____ Signature _____ Print name Vendor: Phone:	
Phone:		Phone:			
Spouse/Parent/Caregiver name:		Insurance/Payer:			
Phone:		Primary:			
Phone:		Secondary:			
Phone:		Tertiary:			
Reason for referral:					
Patient goals:					
Caregiver goals and specific limitations that may affect care:					

HOME ENVIRONMENT:

☐ House ☐ Condo/town home ☐ Apartment ☐ Asst living ☐ LTCF ☐ Own ☐ Rent	
☐ Lives alone ☐ Lives with others -	Hours <u>without</u> assistance:
☐ Home is accessible to patient Comments:	Storage of wheelchair: ☐ In home ☐ Other

COMMUNITY :

TRANSPORTATION:	
☐ Car ☐ Van ☐ Public Transportation ☐ Adapted w/c Lift ☐ Ambulance ☐ Other:	☐ Sits in wheelchair during transport
Where is w/c stored during transport?	☐ Tie Downs ☐ EZ Lock ☐
☐ Self-Driver Drive while in Wheelchair ☐ yes ☐ no	
Employment and/or school:	
Specific requirements pertaining to mobility	
Other:	

COMMUNICATION:

Verbal Communication ☐ WFL receptive ☐ WFL expressive ☐ Understandable ☐ Difficult to understand ☐ non-communicative
Primary Language: _____ 2 nd : _____ Communication provided by: ☐ Patient ☐ Family ☐ Caregiver ☐ Translator
☐ Uses an augmentative communication device Manufacturer/Model :

Name:

MR#:

MEDICAL HISTORY:

Diagnosis:	Diagnosis Code:	Primary Diagnosis:	Diagnosis Code:	Diagnosis:
	Diagnosis Code:	Onset:	Diagnosis:	Diagnosis:
☐ Progressive disease	Relevant future surgeries:			
Height:	Weight:	Explain recent changes or trends in weight:		
History:				
Cardio Status:				
Functional Limitations:				
☐ Intact ☐ Impaired				
Respiratory Status:				
Functional Limitations:				
☐ Intact ☐ Impaired ☐ SOB ☐ COPD ☐ O2 Dependent _____ LPM ☐ Ventilator Dependent				
Resp equip: Objective Measure(s):				
Orthotics:				
☐ Amputee: ☐ Prosthesis:				

MOBILITY/BALANCE:

Sitting Balance	Standing Balance	Transfers	Ambulation
☐ WFL	☐ WFL	☐ Independent	☐ Independent
☐ Uses UE for balance in sitting Comments:	☐ Uses UE/device for stability Comments:	☐ Min assist	☐ Ambulates independently with device: _____
		☐ Mod assist	☐ Able to ambulate _____ feet safely/functionally/independently
☐ Min assist	☐ Min assist	☐ Max assist	☐ Non-functional ambulator History/High risk of falls
☐ Mod assist	☐ Mod assist	☐ Dependent	☐ Unable to ambulate
☐ Max assist	☐ Max assist	Transfer method: ☐ 1 person ☐ 2 person ☐ sliding board ☐ squat pivot	
☐ Unable	☐ Unable	☐ stand pivot ☐ mechanical patient lift ☐ other:	
Fall History: # of falls in the past 6 months? _____ # of "near" falls in the past 6 months? _____			

CURRENT SEATING / MOBILITY:

Current Mobility Device: ☐ None ☐ Cane/Walker ☐ Manual ☐ Dependent ☐ Dependent w/ Tilt ☐ Scooter ☐ Power (type of control):		
Manufacturer:	Model:	Serial #:
Size:	Color:	Age:
Purchased by whom:		
Current condition of mobility base:		
Current seating system:		Age of seating system:
Describe posture in present seating system:		
Is the current mobility meeting medical necessity?: ☐ Yes ☐ No		
Describe:		

Name:

MR#:

Ability to complete Mobility-Related Activities of Daily Living (MRADL's) with Current Mobility Device:

Move room to room	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	Comments:
Meal prep	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	
Feeding	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	
Bathing	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	
Grooming	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	
UE dressing	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	
LE dressing	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	
Toileting	☐ Independent	☐ Min ☐ Mod ☐ Max assist	☐ Unable	
Bowel Mgt: ☐ Continent ☐ Incontinent ☐ Accidents ☐ Diapers ☐ Colostomy ☐ Bowel Program _____				
Bladder Mgt: ☐ Continent ☐ Incontinent ☐ Accidents ☐ Diapers ☐ Urinal ☐ Intermittent Cath ☐ Indwelling Cath ☐ Supra-pubic Cath				

**Current Mobility Equipment Tried/
Ruled Out:**

Does not meet mobility needs due to:
Mark all boxes that indicate inability to use the specific equipment listed

	Meets needs for safe independent functional ambulation / mobility	Risk of Falling or History of Falls	Environmental limitations	Cognition	Safety concerns with physical ability	Decreased / limitations endurance & strength	Decreased / limitations motor skills & coordination	Pain	Pace / Speed	Cardiac and/or respiratory condition	Contra – indicated by diagnosis
Cane/Crutches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walker / Rollator ☐ NA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Manual Wheelchair K0001-K0007: ☐ NA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Manual W/C (K0005) with power assist ☐ NA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Scooter ☐ NA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Power Wheelchair: standard joystick ☐ NA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Power Wheelchair: alternative controls ☐ NA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Summary:

The least costly alternative for independent functional mobility was found to be:

☐ Crutch/Cane ☐ Walker ☐ Manual w/c ☐ Manual w/c with power assist ☐ Scooter ☐ Power w/c std joystick ☐ Power w/c alternative control

☐ Requires **dependent care** mobility device

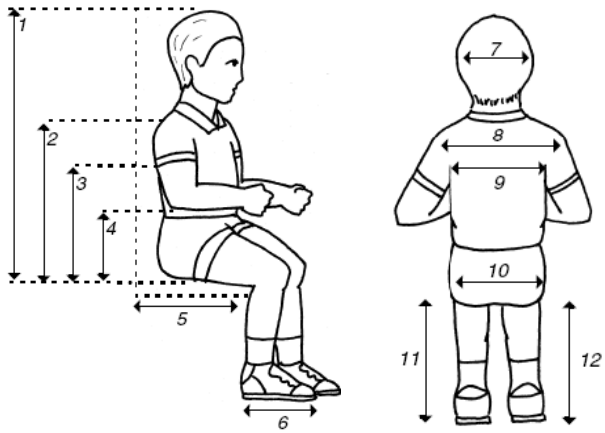
Functional Processing Skills for Wheeled MobilityProcessing skills are adequate for safe mobility equipment operation ☐ Yes ☐ NoPatient is willing and motivated to use recommended mobility equipment ☐ Yes ☐ No☐ Patient is **unable** to safely operate mobility equipment independently and requires **dependent care** equipment

Comments:

Name:

MR#:

Patient Measurements:

	1		Comments/drawings
	2		
	3		
	4		
	5		
	6		
	7		
	8		
	9		
	10		
	11		
	12		

SENSATION and SKIN ISSUES:

Sensation ☐ Intact ☐ Impaired ☐ Absent ☐ Hyposensate ☐ Hypersensate ☐ Defensiveness

Location(s) of impairment: _____

Pressure Relief Method(s): ☐ Lean side to side to offload (without risk of falling) ☐ W/C push up (4+ times/hour for 15+ seconds)
☐ Stand up (without risk of falling) ☐ Other: (Describe) _____

Effective pressure relief method(s) above can be performed consistently throughout the day: ☐ Yes ☐ No

If not, Why? _____

Skin Integrity Risk: ☐ Low risk ☐ Moderate risk ☐ High risk

If high risk, explain: _____

Skin Issues/Skin Integrity

Current skin Issues ☐ Yes ☐ No
☐ Intact ☐ Red area ☐ Open area
☐ Scar tissue ☐ At risk from prolonged sitting
 Where _____

History of Skin Issues ☐ Yes ☐ No
 Where _____
 When _____
 Stage _____

Hx of skin flap surgeries ☐ Yes ☐ No
 Where _____
 When _____

Pain: ☐ Yes ☐ No Location(s): _____ Intensity scale: (0-10) _____

How does pain interfere with mobility and/or MRADLs? -

Name:

MR#

MAT EVALUATION:**Neuro-Muscular Status:** (Tone, Reflexive, Responses, etc.) ☐ Intact☐ Spasticity: _____☐ Hypotonicity ☐ Fluctuating ☐ Muscle Spasms ☐ Poor Righting Reactions/Poor Equilibrium Reactions☐ Primal Reflex(s): _____

Comments:

POSTURE:**COMMENTS:****P
E
L
V
I
S****Anterior / Posterior**☐ Neutral☐ Posterior☐ Anterior

- ☐ Fixed – No movement
☐ Tendency away from neutral
☐ Flexible
☐ Self-correction
☐ External correction

Obliquity (viewed from front)☐ WFL☐ R obliquity
(L elev)☐ L obliquity
(R elev)

- ☐ Fixed – No movement
☐ Tendency away from neutral
☐ Flexible
☐ Self-correction
☐ External correction

Rotation-Pelvis☐ WFL☐ Right
Anterior☐ Left
Anterior

- ☐ Fixed – No movement
☐ Tendency away from neutral
☐ Flexible
☐ Self-correction
☐ External correction

**Tonal Influence
Pelvis:**

- ☐ Normal
☐ Flaccid
☐ Low tone
☐ Spasticity
☐ Dystonia
☐ Pelvic thrust
☐ Other:

TRUNK**Anterior / Posterior**☐ WFL☐ ↑ Thoracic
Kyphosis☐ ↑ Lumbar
Lordosis

- ☐ Fixed – No movement
☐ Tendency away from neutral
☐ Flexible
☐ Self-correction
☐ External correction

Left Right☐ WFL☐ Convex
Left☐ Convex
Right

- ☐ C-curve ☐ S-curve ☐ Multiple
☐ Fixed – No movement
☐ Tendency away from neutral
☐ Flexible
☐ Self-correction
☐ External correction

**Rotation-shoulders and
upper trunk**

- ☐ Neutral
☐ Left-anterior
☐ Right-anterior

- ☐ Fixed – No movement
☐ Tendency away from neutral
☐ Flexible
☐ Self-correction
☐ External correction

**Tonal Influence
Trunk:**

- ☐ Normal
☐ Flaccid
☐ Low tone
☐ Spasticity
☐ Dystonia
☐ Other:

**HEAD
&
NECK**

- ☐ Functional
☐ Flexed ☐ Extended
☐ Rotated R ☐ Lat flexed R
☐ Rotated L ☐ Lat flexed L
☐ Cervical Hyperextension

- ☐ Good head control
☐ Adequate head control
☐ Limited head control
☐ Absent head control

Describe Tone/Movement of head and neck:

Name:

MR#:

H I P S	Position  ☐ Neutral ☐ Abduct ☐ Adduct ☐ Subluxed ☐ Dislocated ☐ Fixed – No movement ☐ Tendency away from neutral ☐ Flexible ☐ Self-correction ☐ External correction			Windswept  ☐ Neutral ☐ Right ☐ Left ☐ Fixed – No movement ☐ Tendency away from neutral ☐ Flexible ☐ Self-correction ☐ External correction			Hip R.O.M / Strength <table border="1"> <thead> <tr> <th></th> <th>WFL</th> <th>Right Limits</th> <th>Left Limits</th> <th>R/L Strength</th> </tr> </thead> <tbody> <tr> <td>Hip Flex</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> <tr> <td>Hip Ext</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> <tr> <td>Hip ABD</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> <tr> <td>Hip Add</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> </tbody> </table>						WFL	Right Limits	Left Limits	R/L Strength	Hip Flex				R ___ /5 L ___ /5	Hip Ext				R ___ /5 L ___ /5	Hip ABD				R ___ /5 L ___ /5	Hip Add				R ___ /5 L ___ /5													
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KNEES & FEET	Knee R.O.M. Right Left ☐ WFL ☐ WFL ☐ Limitations ☐ Limitations Flex Grade R ___ / 5 L ___ / 5 Ext Grade R ___ / 5 L ___ / 5			Foot Positioning ☐ WFL ☐ R ☐ L ROM concerns: Dorsi-Flexed ☐ R ☐ L Plantar Flexed ☐ R ☐ L Inversion ☐ R ☐ L Eversion ☐ R ☐ L Dorsi Grade R ___ / 5 L ___ / 5 Plantar Grade R ___ / 5 L ___ / 5			Tone/Movements LE: ☐ Normal ☐ Low tone ☐ Spasticity ☐ Flaccid ☐ Dystonia ☐ Rocks/Extends at hip ☐ Thrust into knee extension ☐ Pushes legs downward into footrest ☐ Edema LE - <table border="1"> <tbody> <tr> <td>☐ 1+</td> <td>Barely detectable impression when finger is pressed into skin.</td> </tr> <tr> <td>☐ 2+</td> <td>Slight indentation. 15 seconds to rebound</td> </tr> <tr> <td>☐ 3+</td> <td>Deeper indentation. 30 seconds to rebound.</td> </tr> <tr> <td>☐ 4+</td> <td>> 30 seconds to rebound.</td> </tr> </tbody> </table>					☐ 1+	Barely detectable impression when finger is pressed into skin.	☐ 2+	Slight indentation. 15 seconds to rebound	☐ 3+	Deeper indentation. 30 seconds to rebound.	☐ 4+	> 30 seconds to rebound.																														
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U P P E R E X T R E M I T Y	SHOULDERS Tendency Towards: Right Left ☐ Functional ☐ ☐ Elevation ☐ ☐ Depression ☐ ☐ Protraction ☐ ☐ Retraction ☐ ☐ Int-rotation ☐ ☐ Ext-rotation ☐ ☐ Subluxed ☐			R.O.M and Strength for UE: <table border="1"> <thead> <tr> <th></th> <th>WFL</th> <th>Right Limits</th> <th>Left Limits</th> <th>R/L Strength</th> </tr> </thead> <tbody> <tr> <td>Shlder Flex</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> <tr> <td>Shlder ABD</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> <tr> <td>Shlder ADD</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> <tr> <td>Elbow Flex</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> <tr> <td>Elbow Ext</td> <td></td> <td></td> <td></td> <td>R ___ /5 L ___ /5</td> </tr> </tbody> </table> Comments:						WFL	Right Limits	Left Limits	R/L Strength	Shlder Flex				R ___ /5 L ___ /5	Shlder ABD				R ___ /5 L ___ /5	Shlder ADD				R ___ /5 L ___ /5	Elbow Flex				R ___ /5 L ___ /5	Elbow Ext				R ___ /5 L ___ /5	Tone/Movement of ☐ Normal ☐ Flaccid ☐ Low tone ☐ Spasticity ☐ Dystonia ☐ Other: ☐ Edema UE ☐ 1+ ☐ 2+ ☐ 3+ ☐ 4+ Describe:										
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Name:

MR#:

MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION:

MOBILITY BASE	JUSTIFICATION	
Manufacturer: Model: Color: Seat Width: Seat Depth: ☐ Manual mobility base (continue below) ☐ Scooter/POV (continued on page 11) ☐ Power mobility base (cont. on pg 11)	☐ is not a safe, functional ambulator ☐ limitation prevents from completing a MRADL(s) within a reasonable time frame ☐ limitation places at high risk of morbidity or mortality secondary to the attempts to perform a MRADL(s) ☐ limitation prevents accomplishing a MRADL(s) entirely	☐ provide independent mobility ☐ equipment is a lifetime medical need ☐ walker or cane inadequate ☐ any type manual wheelchair inadequate ☐ scooter/POV inadequate ☐ ☐ requires <u>dependent</u> mobility
Number of hours per day spent in above selected mobility base: _____		
Typical daily mobility base use schedule: _____ _____ _____ _____		

MANUAL MOBILITY	
☐ Standard manual wheelchair K0001 Arm: ☐ both ☐ right ☐ left Foot: ☐ both ☐ right ☐ left	☐ self-propels wheelchair ☐ will use on regular basis ☐ chair fits throughout home ☐ willing and motivated to use ☐ propels with assistance ☐ ☐ dependent use
☐ Standard hemi-manual wheelchair K0002 Arm: ☐ both ☐ right ☐ left Foot: ☐ both ☐ right ☐ left	☐ lower seat height required to foot propel ☐ short stature ☐ self-propels wheelchair ☐ will use on regular basis ☐ chair fits throughout home ☐ willing and motivated to use ☐ ☐ propels with assistance ☐ dependent use
☐ Lightweight manual wheelchair K0003 Arm: ☐ both ☐ right ☐ left Foot: ☐ both ☐ right ☐ left ☐ hemi height required	☐ medical condition and weight of wheelchair affect ability to self propel standard manual wheelchair in the residence ☐ can and does self-propel (marginal propulsion skills) ☐ daily use _____ hours ☐ chair fits throughout home ☐ willing and motivated to use ☐ lower seat height required to foot propel ☐ short stature
☐ High strength lightweight manual wheelchair (Breezy Ultra 4) K0004 Arm: ☐ both ☐ right ☐ left Foot: ☐ both ☐ right ☐ left ☐ hemi height required	☐ medical condition and weight of wheelchair affect ability to self propel while engaging in frequent MRADL(s) that cannot be performed in a standard or lightweight manual wheelchair ☐ daily use _____ hours ☐ chair fits throughout home ☐ willing and motivated to use ☐ prevent repetitive use injuries ☐ ☐ lower seat height required to foot propel ☐ short stature

Name:

MR#:

☐ Ultralightweight manual wheelchair K0005 Arm: ☐ both ☐ right ☐ left Foot: ☐ both ☐ right ☐ left ☐ hemi height required ☐ heavy duty Front seat to floor _____ inches Rear seat to floor _____ inches Back height _____ inches Back angle _____ degrees Front angle _____ degrees	☐ full-time manual wheelchair user ☐ Requires individualized fitting and optimal adjustments for multiple features that include adjustable axle configuration, fully adjustable center of gravity, wheel camber, seat and back angle, angle of seat slope, which cannot be accommodated by a K0001 through K0004 manual wheelchair ☐ prevent repetitive use injuries ☐ daily use _____ hours ☐	☐ user has high activity patterns that frequently require them to go out into the community for the purpose of <u>independently</u> accomplishing high level MRADL activities. Examples of these might include a combination of; shopping, work, school, banking, childcare, independently loading and unloading from a vehicle etc. ☐ lower seat height required to foot propel ☐ short stature ☐ heavy duty - weight over 250lbs
☐ Current chair is a K0005 manufacture: _____ model: _____ serial# _____ age: _____ ☐ First time K0005 user (complete trial) K0004 time and # of strokes to propel 30 feet: _____ seconds _____ strokes K0005 time and # of strokes to propel 30 feet: _____ seconds _____ strokes What was the result of the trial between the K0004 and K0005 manual wheelchair? _____ _____ _____ What features of the K0005 w/c are needed as compared to the K0004 base? Why? _____ _____ _____ _____ ☐ adjustable seat and back angle changes the angle of seat slope of the frame to attain a gravity assisted position for efficient propulsion and proper weight distribution along the frame ☐ the front of the wheelchair will be configured higher than the back of the chair to allow gravity to assist the user with postural stability ☐ the center of the wheel will be positioned for stability, safety and efficient propulsion ☐ adjustable axle allows for vertical, horizontal, camber and overall width changes throughout the wheels for adjustment of the client's exact needs and abilities. ☐ adjustable axle increases the stability and function of the chair allowing for adjustment of the center of gravity. ☐ accommodates the client's anatomical position in the chair maximizing independence in mobility and maneuverability in all environments. ☐ create a minimal fixed tilt-in space to assist in positioning. Describe users full-time manual wheelchair activity patterns: _____ _____ _____ _____		

Name:

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☐ Power assist Comments:	☐ prevent repetitive use injuries ☐ repetitive strain injury present in shoulder girdle ☐ shoulder pain is (> or =) to 7/10 during manual propulsion Current Pain ____/10 ☐ requires conservation of energy to participate in MRADL(s) ☐ unable to propel up ramps or curbs using manual wheelchair ☐ been K0005 user greater than one year	☐ user unwilling to use power wheelchair (reason) _____ _____ ☐ less expensive option to power wheelchair ☐ ☐ rim activated power assist – decreased strength
☐ Heavy duty manual wheelchair K0006 Arm: ☐ both ☐ right ☐ left Foot: ☐ both ☐ right ☐ left ☐ hemi height required ☐ Dependent base	☐ user exceeds 250lbs ☐ non-functional ambulator ☐ extreme spasticity ☐ over active movement ☐ broken frame/hx of repeated repairs	☐ able to self-propel in residence ☐ ☐ lower seat to floor height required ☐ unable to self-propel in residence
☐ Extra heavy duty manual wheelchair K0007 Arm: ☐ both ☐ right ☐ left Foot: ☐ both ☐ right ☐ left ☐ hemi height required ☐ Dependent base	☐ user exceeds 300lbs ☐ non-functional ambulator ☐ able to self-propel in residence ☐	☐ lower seat to floor height required ☐ unable to self-propel in residence
☐ Manual wheelchair with tilt E1161 (Manual "Tilt-n-Space")	☐ patient is dependent for transfers ☐ patient requires frequent positioning for pressure relief ☐	☐ patient requires frequent positioning for poor/absent trunk control
☐ Stroller Base	☐ infant/child ☐ unable to propel manual wheelchair ☐ allows for growth ☐ non-functional ambulator	☐ non-functional UE ☐ independent mobility is not a goal at this time ☐
MANUAL FRAME OPTIONS		
☐ Push handles ☐ extended ☐ angle adjustable ☐ standard	☐ caregiver access ☐ caregiver assist	☐ allows "hooking" to enable increased ability to perform ADLs or maintain balance
☐ Angle Adjustable Back	☐ postural control ☐ control of tone/spasticity ☐ accommodation of range of motion	☐ UE functional control ☐ accommodation for seating system ☐
Rear wheel placement ☐ std/fixed ☐ fully adjustable ☐ amputee ☐ camber ____ degree ☐ removable rear wheel ☐ non-removable rear wheel Wheel size ____ Wheel style ____	☐ improved UE access to wheels ☐ increase propulsion ability ☐ improved stability ☐ changing angle in space for improvement of postural stability ☐ remove for transport	☐ allow for seating system to fit on base ☐ amputee placement ☐ 1-arm drive access ☐ R ☐ L ☐ enable propulsion of manual wheelchair with one arm ☐ amputee placement

Name:

MR#:

Wheel rims/ Hand rims ☐ Standard ☐ Specialized-_____	☐ provide ability to propel manual wheelchair	☐ increase self-propulsion with hand weakness/decreased grasp
☐ Spoke protector/guard	☐ prevent hands from getting caught in spokes	
Tires: ☐ pneumatic ☐ flat free inserts ☐ solid Style:	☐ decrease roll resistance ☐ increase shock absorbency ☐ decrease pain from road shock ☐ decrease spasms from road shock	☐ prevent frequent flats ☐ decrease maintenance
Wheel Locks: ☐ push ☐ pull ☐ scissor	☐ lock wheels for transfers	☐ lock wheels from rolling
Brake/wheel lock extension: ☐ R ☐ L	☐ allow user to operate wheel locks due to decreased reach or strength	
Caster housing: Caster size: Style: ☐ suspension fork	☐ maneuverability ☐ stability of wheelchair ☐ durability ☐ maintenance ☐ angle adjustment for posture ☐ allow for feet to come under wheelchair base	☐ allows change in seat to floor height ☐ ☐ increase shock absorbency ☐ decrease pain from road shock ☐ decrease spasms from road shock
☐ Side guards	☐ prevent clothing getting caught in wheel or becoming soiled ☐ provide hip and pelvic stability	☐ eliminates contact between body and wheels ☐ limit hand contact with wheels
☐ Anti-tippers	☐ prevent wheelchair from tipping backward	☐ assist caregiver with curbs

POWER MOBILITY		
☐ Scooter/POV	☐ can safely operate ☐ can safely transfer ☐ has adequate trunk stability	☐ cannot functionally propel manual wheelchair ☐
☐ Power mobility base	☐ non-ambulatory ☐ cannot functionally propel manual wheelchair ☐ cannot functionally and safely operate scooter/POV	☐ can safely operate power wheelchair ☐ home is accessible ☐ willing to use power wheelchair ☐
Tilt ☐ Powered tilt on powered chair ☐ Powered tilt on manual chair ☐ Manual tilt on manual chair Comments:	☐ change position for pressure relief/cannot weight shift ☐ change position against gravitational force on head and shoulders ☐ decrease pain ☐ blood pressure management ☐ control autonomic dysreflexia ☐ decrease respiratory distress	☐ management of spasticity ☐ management of low tone ☐ facilitate postural control ☐ rest periods ☐ control edema ☐ increase sitting tolerance ☐ aid with transfers ☐

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Recline ☐ Power recline on power chair ☐ Manual recline on manual chair Comments:	☐ intermittent catheterization ☐ manage spasticity ☐ accommodate femur to back angle ☐ change position for pressure relief/cannot weight shift ☐ high risk of pressure sore development ☐ tilt alone does not accomplish effective pressure relief, maximum pressure relief achieved at - _____ degrees tilt _____ degrees recline ☐	☐ difficult to transfer to and from bed ☐ rest periods and sleeping in chair ☐ repositioning for transfers ☐ bring to full recline for ADL care ☐ clothing/diaper changes in chair ☐ gravity PEG tube feeding ☐ head positioning ☐ decrease pain ☐ blood pressure management ☐ control autonomic dysreflexia ☐ decrease respiratory distress ☐ user on ventilator
Elevator on mobility base ☐ Power wheelchair ☐ Scooter	☐ increase Indep in transfers ☐ increase Indep in ADLs ☐ bathroom function and safety ☐ kitchen/cooking function and safety ☐ shopping ☐ raise height for communication at standing level	☐ raise height for eye contact which reduces cervical neck strain and pain ☐ drive at raised height for safety and navigating crowds ☐ Other:
☐ Vertical position system (anterior tilt) (Drive locks-out) ☐ Stand (Drive enabled)	☐ independent weight bearing ☐ decrease joint contractures ☐ decrease/manage spasticity ☐ decrease/manage spasms ☐ pressure distribution away from scapula, sacrum, coccyx, and ischial tuberosity ☐ increase digestion and elimination	☐ access to counters and cabinets ☐ increase reach ☐ increase interaction with others at eye level, reduces neck strain ☐ increase performance of MRADL(s) ☐
Power elevating legrest ☐ Center mount (Single) 85-170 degrees ☐ Standard (Pair) 100-170 degrees	☐ position legs at 90 degrees, not available with std power ELR ☐ center mount tucks into chair to decrease turning radius in home, not available with std power ELR ☐ provide change in position for LE ☐ elevate legs during recline ☐ maintain placement of feet on footplate	☐ decrease edema ☐ improve circulation ☐ actuator needed to elevate legrest ☐ actuator needed to articulate legrest preventing knees from flexing ☐ Increase ground clearance over curbs ☐ STD (pair) independently elevate legrest
POWER WHEELCHAIR CONTROLS		
Controls/input device ☐ Expandable ☐ Non-expandable ☐ Proportional ☐ Right Hand ☐ Left Hand ☐ Non-proportional/switches/head-array ☐ Electrical/proximity ☐ Mechanical Manufacturer: _____ Type: _____	☐ provides access for controlling wheelchair ☐ programming for accurate control ☐ progressive disease/changing condition ☐ required for alternative drive controls	☐ lacks motor control to operate proportional drive control ☐ unable to understand proportional controls ☐ limited movement/strength ☐ extraneous movement / tremors / ataxic / spastic

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☐ Upgraded electronics controller/harness ☐ Single power (tilt <u>or</u> recline) ☐ Expandable ☐ Non-expandable plus ☐ Multi-power (tilt, recline, power legrest, power seat lift, vertical positioning system, stand)	☐ allows input device to communicate with drive motors ☐ harness provides necessary connections between the controller, input device, and seat functions ☐	☐ needed in order to operate power seat functions through joystick/ input device ☐ required for alternative drive controls
☐ Enhanced display	☐ required to connect all alternative drive controls ☐ required for upgraded joystick (lite-throw, heavy duty, micro)	☐ Allows user to see in which mode and drive the wheelchair is set; necessary for alternate controls
☐ Upgraded tracking electronics	☐ correct tracking when on uneven surfaces ☐ makes switch driving more efficient and less fatiguing	☐ increase safety when driving ☐ increase ability to traverse thresholds
☐ Safety / reset / mode switches Type:	☐ Used to change modes and stop the wheelchair when driving	
☐ Mount for joystick / input device/ switches	☐ swing away for access or transfers ☐ attaches joystick / input device / switches to wheelchair	☐ provides for consistent access ☐ midline for optimal placement ☐
☐ Attendant controlled joystick plus mount	☐ safety ☐ long distance driving ☐ operation of seat functions	☐ compliance with transportation regulations ☐
☐ Battery	☐ required to power (power assist / scooter/ power wc / other):	
☐ Power inverter (24V to 12V)	☐ required for ventilator / respiratory equipment / other:	

CHAIR OPTIONS MANUAL & POWER

Armrests ☐ adjustable height ☐ removable ☐ swing away ☐ fixed ☐ flip back ☐ reclining ☐ full length pads ☐ desk ☐ tube arms ☐ gel pads	☐ provide support with elbow at 90 ☐ remove/flip back/swing away for transfers ☐ provide support and positioning of upper body	☐ allow to come closer to table top ☐ remove for access to tables ☐ provide support for w/c tray ☐ change of height/angles for variable activities
☐ Elbow support / Elbow stop	☐ keep elbow positioned on arm pad	☐ keep arms from falling off arm pad during tilt and/or recline
Upper Extremity Support ☐ Arm trough ☐ R ☐ L Style: ☐ swivel mount ☐ fixed mount ☐ posterior hand support ☐ ½ tray ☐ full tray ☐ joystick cut out ☐ R ☐ L Style:	☐ decrease gravitational pull on shoulders ☐ provide support to increase UE function ☐ provide hand support in natural position ☐ position flaccid UE ☐ decrease subluxation ☐ decrease edema	☐ manage spasticity ☐ provide midline positioning ☐ provide work surface ☐ placement for AAC/Computer/EADL

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Hangers/ Legrests ☐ _____ degree ☐ elevating ☐ articulating ☐ swing away ☐ fixed ☐ lift off ☐ heavy duty ☐ adjustable knee angle ☐ adjustable calf panel ☐ longer extension tube	☐ provide LE support ☐ maintain placement of feet on footplate ☐ accommodate lower leg length ☐ accommodate to hamstring tightness	☐ enable transfers ☐ provide change in position for LE's ☐ elevate legs during recline ☐ decrease edema ☐ durability ☐
Foot support ☐ footplate ☐ R ☐ L ☐ flip up ☐ depth adjustable ☐ angle adjustable ☐ foot board/one piece	☐ provide foot support ☐ accommodate to ankle ROM ☐ allow foot to go under wheelchair base	☐ enable transfers ☐
☐ Shoe holders	☐ position foot ☐ decrease / manage spasticity ☐ control position of LE	☐ stability ☐ safety ☐
☐ Ankle strap/heel loops	☐ support foot on foot support ☐ decrease extraneous movement	☐ provide input to heel ☐ protect foot
☐ Amputee adapter ☐ R ☐ L Style: _____ Size: _____	☐ Provide support for stump/residual extremity	☐
☐ Transportation tie-down	☐ to provide crash tested tie-down brackets ☐	
☐ Crutch/cane holder ☐ O2 holder ☐ IV hanger ☐ Ventilator tray/mount	☐ stabilize accessory on wheelchair ☐	
Component	Justification	
☐ Seat cushion	☐ accommodate impaired sensation ☐ decubitus ulcers present or history ☐ unable to shift weight ☐ increase pressure distribution ☐ prevent pelvic extension ☐ custom required "off-the-shelf" seat cushion will not accommodate deformity	☐ stabilize/promote pelvis alignment ☐ stabilize/promote femur alignment ☐ accommodate obliquity ☐ accommodate multiple deformity ☐ incontinent/accidents ☐ low maintenance ☐
☐ seat mounts ☐ fixed ☐ removable	☐ attach <u>seat</u> platform/cushion to wheelchair frame	
☐ Seat wedge	☐ provide increased aggressiveness of seat shape to decrease sliding down in the seat ☐ accommodate ROM ☐	
☐ Cover replacement	☐ protect back or seat cushion	☐ incontinent/accidents
☐ Solid seat / insert	☐ support cushion to prevent hammocking	☐ allows attachment of cushion to mobility base
☐ Lateral pelvic/thigh/hip support (Guides)	☐ decrease abduction ☐ accommodate pelvis ☐ position upper legs	☐ accommodate spasticity ☐ removable for transfers ☐
☐ Lateral pelvic/thigh supports mounts ☐ fixed ☐ swing-away ☐ removable	☐ mounts lateral pelvic/thigh supports	☐ mounts lateral pelvic/thigh supports swing-away or removable for transfers
☐ Medial thigh support (Pommel)	☐ decrease adduction ☐ accommodate ROM	☐ remove for transfers ☐ alignment
☐ Medial thigh support mounts ☐ fixed ☐ swing-away ☐ removable	☐ mounts medial thigh supports	☐ mounts medial supports swing-away or removable for transfers

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Component	Justification
☐ Back	☐ provide posterior trunk support ☐ provide lumbar/sacral support ☐ support trunk in midline ☐ provide lateral trunk support ☐ accommodate or decrease tone ☐
☐ Back mounts ☐ fixed ☐ removable	☐ attach <u>back</u> rest/cushion to wheelchair frame
☐ Lateral trunk supports ☐ R ☐ L	☐ decrease lateral trunk leaning ☐ accommodate asymmetry ☐ contour for increased contact ☐
☐ Lateral trunk supports mounts ☐ fixed ☐ swing-away ☐ removable	☐ mounts lateral trunk supports ☐ mounts lateral trunk supports swing-away or removable for transfers
☐ Anterior chest strap, vest	☐ decrease forward movement of shoulder ☐ decrease forward movement of trunk ☐ safety/stability ☐
☐ Headrest	☐ provide posterior head support ☐ provide posterior neck support ☐ provide lateral head support ☐ provide anterior head support ☐ support during tilt and recline ☐ improve feeding ☐
☐ Headrest mounting hardware ☐ fixed ☐ removable ☐ flip down ☐ swing-away laterals/switches	☐ mount headrest ☐ mounts headrest flip down or removable for transfers ☐
☐ Neck Support	☐ decrease neck rotation ☐ decrease forward neck flexion
Pelvic Positioner ☐ std hip belt ☐ ☐ padded hip belt ☐ dual pull hip belt ☐ four point hip belt	☐ stabilize tone ☐ decrease falling out of chair ☐ prevent excessive extension ☐ special pull angle to control rotation ☐
☐ Essential needs bag/pouch	☐ medicines ☐ special food ☐ orthotics ☐ clothing changes ☐ diapers ☐ catheter/hygiene ☐ ostomy supplies ☐
☐	
☐	
The above equipment has a life- long use expectancy. Growth and changes in medical and/or functional conditions would be the exceptions.	

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SUMMARY:

[illegible]

SIGNATURE:

As the evaluating therapist, I hereby attest that I have personally completed this evaluation and that I am not an employee of or working under contract to the manufacturer(s) or the provider(s) of the durable medical equipment recommended in my evaluation. I further attest that I have not and will not receive remuneration of any kind from the manufacturer(s) or the durable medical equipment provider(s) for the equipment I have recommended with this evaluation.

Therapist name printed:		License:
Therapist's signature:		Date:

I concur with the above findings and recommendations of the therapist:

Physician name printed:		
Physician's signature:		Date: