

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:

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

COMMUNITY :

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

COMMUNICATION:

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

Name:

MR#:

MEDICAL HISTORY:

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

MOBILITY/BALANCE:

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

CURRENT SEATING / MOBILITY:

Current Mobility Device: <input type="checkbox"/> None <input type="checkbox"/> Cane/Walker <input type="checkbox"/> Manual <input type="checkbox"/> Dependent <input type="checkbox"/> Dependent w/ Tilt <input type="checkbox"/> Scooter <input type="checkbox"/> 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?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Describe:		

Name:

MR#:

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

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

EQUIPMENT TRIALS:***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	Enviro- mental limita- tions	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walker / Rollator <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Wheelchair K0001-K0007: <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual W/C (K0005) with power assist <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scooter <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power Wheelchair: standard joystick <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Power Wheelchair: alternative controls <input type="checkbox"/> NA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

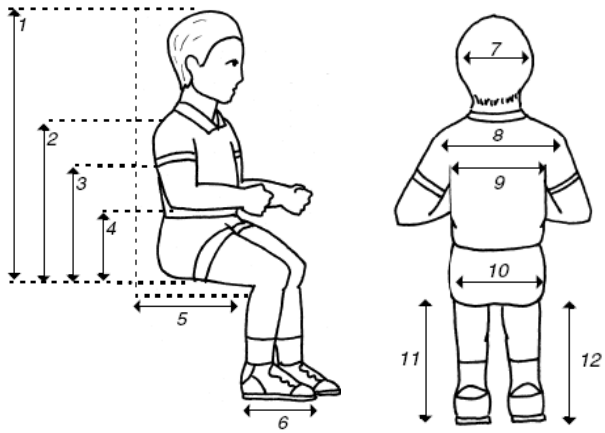
Functional Processing Skills for Wheeled MobilityProcessing skills are adequate for safe mobility equipment operation ☐ Yes ☐ NoPatient is willing and motivated to use recommended mobility equipment ☐ Yes ☐ No☐ Patient is **unable** to safely operate mobility equipment independently and requires **dependent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

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

If not, Why? _____

Pressure Map Results: The above method(s) provided effective pressure relief - ☐ Yes ☐ No

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? -

Braden Scale For Predicting Pressure Sore Risk ©

Risk Factor	Score/Description				Score
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	<input type="checkbox"/> 1. COMPLETELY LIMITED Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface	<input type="checkbox"/> 2. VERY LIMITED – Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	<input type="checkbox"/> 3. SLIGHTLY LIMITED – Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	<input type="checkbox"/> 4. NO IMPAIRMENT – Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
MOISTURE Degree to which skin is exposed to moisture	<input type="checkbox"/> 1. CONSTANTLY MOIST – Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	<input type="checkbox"/> 2. OFTEN MOIST – Skin is often but not always moist. Linen must be changed at least once a shift.	<input type="checkbox"/> 3. OCCASIONALLY MOIST – Skin is occasionally moist, requiring an extra linen change approximately once a day.	<input type="checkbox"/> 4. RARELY MOIST – Skin is usually dry; linen only requires changing at routine intervals.	
ACTIVITY Degree of physical activity	<input type="checkbox"/> 1. BEDFAST – Confined to bed	<input type="checkbox"/> 2. CHAIRFAST – Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair	<input type="checkbox"/> 3. WALKS OCCASIONALLY – Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<input type="checkbox"/> 4. WALKS FREQUENTLY– Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
MOBILITY Ability to change and control body position	<input type="checkbox"/> 1. COMPLETELY IMMOBILE – Does not make even slight changes in body or extremity position without assistance.	<input type="checkbox"/> 2. VERY LIMITED – Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	<input type="checkbox"/> 3. SLIGHTLY LIMITED – Makes frequent though slight changes in body or extremity position independently	<input type="checkbox"/> 4. NO LIMITATIONS – Makes major and frequent changes in position without assistance.	
NUTRITION Usual food intake pattern 1NPO: Nothing by mouth. 2IV: Intravenously. 3TPN: Total parenteral nutrition.	<input type="checkbox"/> 1. VERY POOR – Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO1 and/or maintained on clear liquids or IV2 for more than 5 days	<input type="checkbox"/> 2. PROBABLY INADEQUATE – Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	<input type="checkbox"/> 3. ADEQUATE – Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN3 regimen, which probably meets most of nutritional needs.	<input type="checkbox"/> 4. EXCELLENT – Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	
FRICITION AND SHEAR	<input type="checkbox"/> 1. PROBLEM- Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	<input type="checkbox"/> 2. POTENTIAL PROBLEM– Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	<input type="checkbox"/> 3. NO APPARENT PROBLEM – Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		
Source: Barbara Braden and Nancy Bergstrom. Copyright, 1988. Reprinted with permission. All rights reserved					Total
Braden Scale Score: <input type="checkbox"/> Very High Risk 6-9 <input type="checkbox"/> High Risk 10-12 <input type="checkbox"/> Moderate Risk 13-14 <input type="checkbox"/> Mild Risk 15-18 <input type="checkbox"/> No Risk 19-23					

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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

☐

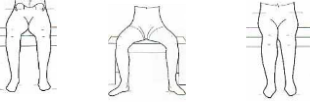

Convex

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  <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct <input type="checkbox"/> Subluxed <input type="checkbox"/> Dislocated <input type="checkbox"/> Fixed – No movement <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible <input type="checkbox"/> Self-correction <input type="checkbox"/> External correction			Windswept  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Fixed – No movement <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible <input type="checkbox"/> Self-correction <input type="checkbox"/> 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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Contractures		<input type="checkbox"/>	<input type="checkbox"/>																																														
Fisting		<input type="checkbox"/>	<input type="checkbox"/>																																														
Tremors		<input type="checkbox"/>	<input type="checkbox"/>																																														
Weak grasp		<input type="checkbox"/>	<input type="checkbox"/>																																														
Poor dexterity		<input type="checkbox"/>	<input type="checkbox"/>																																														
Hand movement non-functional		<input type="checkbox"/>	<input type="checkbox"/>																																														
Paralysis		<input type="checkbox"/>	<input type="checkbox"/>																																														

Name:

MR#:

MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION:

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

MANUAL MOBILITY		
<input type="checkbox"/> Standard manual wheelchair K0001 Arm: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left Foot: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> self-propels wheelchair <input type="checkbox"/> will use on regular basis <input type="checkbox"/> chair fits throughout home <input type="checkbox"/> willing and motivated to use	<input type="checkbox"/> propels with assistance <input type="checkbox"/> <input type="checkbox"/> dependent use
<input type="checkbox"/> Standard hemi-manual wheelchair K0002 Arm: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left Foot: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left	<input type="checkbox"/> lower seat height required to foot propel <input type="checkbox"/> short stature <input type="checkbox"/> self-propels wheelchair <input type="checkbox"/> will use on regular basis	<input type="checkbox"/> chair fits throughout home <input type="checkbox"/> willing and motivated to use <input type="checkbox"/> <input type="checkbox"/> propels with assistance <input type="checkbox"/> dependent use
<input type="checkbox"/> Lightweight manual wheelchair K0003 Arm: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left Foot: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> hemi height required	<input type="checkbox"/> medical condition and weight of wheelchair affect ability to self propel standard manual wheelchair in the residence <input type="checkbox"/> can and does self-propel (marginal propulsion skills)	<input type="checkbox"/> daily use _____ hours <input type="checkbox"/> chair fits throughout home <input type="checkbox"/> willing and motivated to use <input type="checkbox"/> lower seat height required to foot propel <input type="checkbox"/> short stature
<input type="checkbox"/> High strength lightweight manual wheelchair (Breezy Ultra 4) K0004 Arm: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left Foot: <input type="checkbox"/> both <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> hemi height required	<input type="checkbox"/> 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 <input type="checkbox"/> daily use _____ hours	<input type="checkbox"/> chair fits throughout home <input type="checkbox"/> willing and motivated to use <input type="checkbox"/> prevent repetitive use injuries <input type="checkbox"/> <input type="checkbox"/> lower seat height required to foot propel <input type="checkbox"/> 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 independently 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:

MR#:

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

Name:

MR#:

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

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

Name:

MR#:

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

Name:

MR#:

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

CHAIR OPTIONS MANUAL & POWER

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

Name:

MR#:

Hangers/ Legrests <input type="checkbox"/> _____ degree <input type="checkbox"/> elevating <input type="checkbox"/> articulating <input type="checkbox"/> swing away <input type="checkbox"/> fixed <input type="checkbox"/> lift off <input type="checkbox"/> heavy duty <input type="checkbox"/> adjustable knee angle <input type="checkbox"/> adjustable calf panel <input type="checkbox"/> longer extension tube	<input type="checkbox"/> provide LE support <input type="checkbox"/> maintain placement of feet on footplate <input type="checkbox"/> accommodate lower leg length <input type="checkbox"/> accommodate to hamstring tightness	<input type="checkbox"/> enable transfers <input type="checkbox"/> provide change in position for LE's <input type="checkbox"/> elevate legs during recline <input type="checkbox"/> decrease edema <input type="checkbox"/> durability <input type="checkbox"/>
Foot support <input type="checkbox"/> footplate <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> flip up <input type="checkbox"/> depth adjustable <input type="checkbox"/> angle adjustable <input type="checkbox"/> foot board/one piece	<input type="checkbox"/> provide foot support <input type="checkbox"/> accommodate to ankle ROM <input type="checkbox"/> allow foot to go under wheelchair base	<input type="checkbox"/> enable transfers <input type="checkbox"/>
<input type="checkbox"/> Shoe holders	<input type="checkbox"/> position foot <input type="checkbox"/> decrease / manage spasticity <input type="checkbox"/> control position of LE	<input type="checkbox"/> stability <input type="checkbox"/> safety <input type="checkbox"/>
<input type="checkbox"/> Ankle strap/heel loops	<input type="checkbox"/> support foot on foot support <input type="checkbox"/> decrease extraneous movement	<input type="checkbox"/> provide input to heel <input type="checkbox"/> protect foot
<input type="checkbox"/> Amputee adapter <input type="checkbox"/> R <input type="checkbox"/> L Style: Size:	<input type="checkbox"/> Provide support for stump/residual extremity	<input type="checkbox"/>
<input type="checkbox"/> Transportation tie-down	<input type="checkbox"/> to provide crash tested tie-down brackets <input type="checkbox"/>	
<input type="checkbox"/> Crutch/cane holder <input type="checkbox"/> O2 holder <input type="checkbox"/> IV hanger <input type="checkbox"/> Ventilator tray/mount	<input type="checkbox"/> stabilize accessory on wheelchair <input type="checkbox"/>	
Component	Justification	
<input type="checkbox"/> Seat cushion	<input type="checkbox"/> accommodate impaired sensation <input type="checkbox"/> decubitus ulcers present or history <input type="checkbox"/> unable to shift weight <input type="checkbox"/> increase pressure distribution <input type="checkbox"/> prevent pelvic extension	<input type="checkbox"/> stabilize/promote pelvis alignment <input type="checkbox"/> stabilize/promote femur alignment <input type="checkbox"/> accommodate obliquity <input type="checkbox"/> accommodate multiple deformity <input type="checkbox"/> incontinent/accidents <input type="checkbox"/> low maintenance <input type="checkbox"/>
<input type="checkbox"/> seat mounts <input type="checkbox"/> fixed <input type="checkbox"/> removable	<input type="checkbox"/> attach <u>seat</u> platform/cushion to wheelchair frame	
<input type="checkbox"/> Seat wedge	<input type="checkbox"/> provide increased aggressiveness of seat shape to decrease sliding down in the seat <input type="checkbox"/> accommodate ROM <input type="checkbox"/>	
<input type="checkbox"/> Cover replacement	<input type="checkbox"/> protect back or seat cushion	<input type="checkbox"/> incontinent/accidents
<input type="checkbox"/> Solid seat / insert	<input type="checkbox"/> support cushion to prevent hammocking	<input type="checkbox"/> allows attachment of cushion to mobility base
<input type="checkbox"/> Lateral pelvic/thigh/hip support (Guides)	<input type="checkbox"/> decrease abduction <input type="checkbox"/> accommodate pelvis <input type="checkbox"/> position upper legs	<input type="checkbox"/> accommodate spasticity <input type="checkbox"/> removable for transfers <input type="checkbox"/>
<input type="checkbox"/> Lateral pelvic/thigh supports mounts <input type="checkbox"/> fixed <input type="checkbox"/> swing-away <input type="checkbox"/> removable	<input type="checkbox"/> mounts lateral pelvic/thigh supports	<input type="checkbox"/> mounts lateral pelvic/thigh supports swing-away or removable for transfers
<input type="checkbox"/> Medial thigh support (Pommel)	<input type="checkbox"/> decrease adduction <input type="checkbox"/> accommodate ROM	<input type="checkbox"/> remove for transfers <input type="checkbox"/> alignment
<input type="checkbox"/> Medial thigh support mounts <input type="checkbox"/> fixed <input type="checkbox"/> swing-away <input type="checkbox"/> removable	<input type="checkbox"/> mounts medial thigh supports	<input type="checkbox"/> mounts medial supports swing-away or removable for transfers

Name:

MR#:

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

Name:

MR#:

SUMMARY:

Why mobility device was selected; include why a lower level device is not appropriate:

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: