Functional Mobility & Wheelchair Assessment ©

PATIENT INFORMATION:

Name:	**DOB:** **Sex:** M ☑ F	**Date:**
Address:	**Physician:** Phone:	*The following **ATP** was present and participated in this evaluation*
Phone:	**Therapist:** Phone:	Signature
Spouse/Parent/Caregiver name: Phone: Phone:	**Insurance/Payer:** Primary: Secondary: Tertiary:	Print name Vendor: Phone:
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 without assistance:**
❒Home is accessible to patient Storage of wheelchair: ❒In home ❒Other Comments:	

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 Langua micaela jodi dupagen	ation provided by:❒Patient ❒Family ❒Caregiver ❒Translator
❒Uses an augr	el :

Name: MR#:

MEDICAL HISTORY:

Diagnosis:	Diagnosis Code:	**Primary Diagnosis**: **Onset:**	Diagnosis Code:	Diagnosis:
	Diagnosis Code:	Diagnosis:	Diagnosis Code:	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 ❒stand pivot ❒mechanical patient lift ❒other:	
❒ Unable	❒ Unable		

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

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	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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 Mobility

Processing skills are adequate for safe mobility equipment operation ☐ **Yes** ☐ **No**

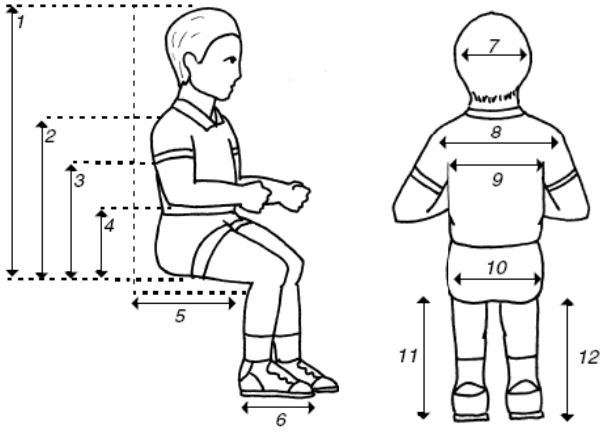
Patient is willing and motivated to use recommended mobility equipment ☐ **Yes** ☐ **No**

☐ Patient is **unable** to safely operate mobility equipment independently and requires **dependent care** equipment

Comments:

Name: MR#:

Patient Measurements:



		Comments/drawings
1		
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? -

Name: MR#:

Braden Scale For Predicting Pressure Sore Risk ©

Risk Factor	Score/Description				Score
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	❒ 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	❒ 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.	❒ 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.	❒ 4. **NO IMPAIRMENT** – Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	0
MOISTURE Degree to which skin is exposed to moisture	❒ 1. **CONSTANTLY MOIST**– Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	❒ 2. **OFTEN MOIST** – Skin is often but not always moist. Linen must be changed at least once a shift.	❒ 3. **OCCASIONALLY MOIST** – Skin is occasionally moist, requiring an extra linen change approximately once a day.	❒ 4. **RARELY MOIST** – Skin is usually dry; linen only requires changing at routine intervals.	0
ACTIVITY Degree of physical activity	❒ 1. **BEDFAST** – Confined to bed	❒ 2. **CHAIRFAST** – Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair	❒ 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.	❒ 4. **WALKS FREQUENTLY**– Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	0
MOBILITY Ability to change and control body position	❒ 1. **COMPLETELY IMMOBILE –** Does not make even slight changes in body or extremity position without assistance.	❒ 2. **VERY LIMITED** – Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	❒ 3. **SLIGHTLY LIMITED** – Makes frequent though slight changes in body or extremity position independently	❒ 4. **NO LIMITATIONS** – Makes major and frequent changes in position without assistance.	0
NUTRITION Usual food intake pattern 1NPO: Nothing by mouth. 2IV: Intravenously. 3TPN: Total parenteral nutrition.	❒ 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	❒ 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.	❒ 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.	❒ 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.	0
FRICTION AND SHEAR	❒ 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.	❒ 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.	❒ 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.		0
Source: Barbara Braden and Nancy Bergstrom. Copyright, 1988. Reprinted with permission. All rights reserved				**Total**	0
Braden Scale Score: ❒Very High Risk 6-9 ❒High Risk 10-12 ❒Moderate Risk 13-14 ❒Mild Risk 15-18 ❒No Risk 19-23					

Name: MR#:

MAT EVALUATION:

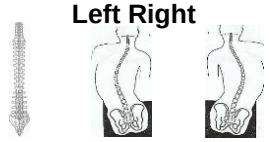
Neuro-Muscular Status: (Tone, Reflexive, Responses, etc.) ❒ Intact

❒Spasticity: _____

❒Hypotonicity ❒Fluctuating ❒Muscle Spasms ❒Poor Righting Reactions/Poor Equilibrium Reactions

❒Primal Reflex(s): _____

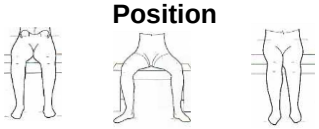
Comments:

POSTURE:				**COMMENTS:**
PELVIS	**Anterior / Posterior**  ❒ Neutral ❒ Posterior ❒ Anterior ❒Fixed – No movement ❒Tendency away from neutral ❒Flexible ❒Self-correction ❒External correction	**Obliquity** (viewed from from)  ❒ 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#:

HIPS

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

	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

Tone/Movements LE:

❒Normal ❒Low tone ❒Spasticity ❒Flaccid ❒Dystonia

❒Rocks/Extends at hip ❒Thrust into knee extension

❒Pushes legs downward into footrest

❒Edema LE -_____

❒ 1+	Barely detectable impression when finger is presssed into skin.
❒ 2+	Slight indentation. 15 seconds to rebound
❒ 3+	Deeper indentation. 30 seconds to rebound.
❒ 4+	> 30 seconds to rebound.

KNEES & FEET

Knee R.O.M.

Right ❒WFL ❒Limitations

Left ❒WFL ❒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

UPPER EXTREMITY

SHOULDERS

Tendency Towards:

Right		Left
❒	Functional	❒
❒	Elevation	❒
❒	Depression	❒
❒	Protraction	❒
❒	Retraction	❒
❒	Int-rotation	❒
❒	Ext-rotation	❒
❒	Subluxed	❒

R.O.M and Strength for UE:

	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

Comments:

Tone/Movement of

❒Normal

❒Flaccid

❒Low tone

❒Spasticity

❒Dystonia

❒Other:

❒Edema UE

❒1+ ❒2+ ❒3+ ❒4+

Describe:

Wrist & Hand

Handedness:

❒Right

❒Left

❒NA

Comments:

WNL	❒ Right	❒ Left
Limitations	❒	❒
Contractures	❒	❒
Fisting	❒	❒
Tremors	❒	❒
Weak grasp	❒	❒
Poor dexterity	❒	❒
Hand movement non-functional	❒	❒
Paralysis	❒	❒

Flex Grade **R**____ / 5 **L**____ / 5

Ext Grade **R**____ / 5 **L**____ / 5

Pinch Strength _____

Grip Strength _____

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 dependent 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

❒**<u>Current chair is a K0005</u>** manufacture:_____ model:_____ serial#_____ age:70_____

❒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#:

❒**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

Name: MR#:

❒**Upgraded electronics controller/harness** ❒Single power (tilt **or** 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

Name: MR#:

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 ❒depthadjustable ❒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	❒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

Name: MR#:

Component	Justification
❒**Back**	❒provide posterior trunk support ❒facilitate tone ❒provide lumbar/sacral support ❒accommodate deformity ❒support trunk in midline ❒custom required "off-the-shelf" back support will not accommodate deformity ❒provide lateral trunk support ❒accommodate or decrease tone ❒
❒**Back mounts** ❒*fixed* ❒*removable*	❒attach back rest/cushion to wheelchair frame
❒**Lateral trunk supports** ❒R ❒L	❒decrease lateral trunk leaning ❒safety ❒accommodate asymmetry ❒control of tone ❒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 ❒added abdominal support ❒decrease forward movement of trunk ❒trunk alignment ❒safety/stability ❒assistance with shoulder control ❒decrease shoulder elevation ❒
❒**Headrest**	❒provide posterior head support ❒improve respiration ❒provide posterior neck support ❒placement of switches ❒provide lateral head support ❒safety ❒provide anterior head support ❒accommodate ROM ❒support during tilt and recline ❒accommodate tone ❒improve feeding ❒improve visual orientation
❒**Headrest mounting hardward** ❒*fixed* ❒*removable* ❒*flip down* ❒*swing-away* laterals/switches	❒mount headrest ❒mount headrest swing-away laterals ❒mounts headrest flip down or removable for transfers ❒mount switches ❒
❒**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 ❒pad for protection over boney prominence ❒decrease falling out of chair ❒prevent excessive extension ❒promote comfort ❒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.	

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:**