WHEELCHAIR SEATING EVALUATION FORM

**CLIENT’S NAME**

**CLIENT’S MEDICAID #**

**CLIENT’S DATE OF BIRTH**

**CLIENT’S ADDRESS**

**ICD-10 CODE(S)**

**HEIGHT**

**WEIGHT**

**IS A WHEELCHAIR CURRENTLY IN USE?** YES NO

**If no, what is the current mode of transportation?**

Note: A current wheelchair seating assessment conducted by a physical or occupational therapist must be completed for purchase of or modifications (including new seating systems) to a customized wheelchair. Please attach manufacturer information, descriptions and an itemized list of retail prices of all additions that are not included in base model price.

**Neurological Factors:**

**Client’s muscle tone**: Hypertonic: Fluctuating Absent\_\_\_\_\_ NA\_\_\_\_\_\_

**Describe client’s muscle tone:**

**Describe active movements affected by muscle tone:**

**Describe reflexes present:**

**Postural Control:**

**Head Control:**

**Trunk Control:**

**Upper Extremities:**

**Lower Extremities:**

**Medical/Surgery Hx and Plan:**

**Is there any history of decubitus/skin breakdown?** YES\_\_\_\_\_\_\_NO\_\_\_\_\_\_

**If the answer is yes, please explain (Lack of sensation, inability to perform an effective weight shift, etc.):**

**Describe orthopedic conditions and/or range of motion limitations requiring special considerations (i.e.: contractures, degree of spinal curvature):**

**Describe other physical limitations or concerns (i.e. respiratory):**

**Describe any recent or expected changes in medical physical functional status:**

**If surgery is anticipated, please indicate the procedure and expected date:**

**Functional Assessment:**

**Ambulatory Status:**

**Indicate the client’s ambulation potential:**

**Wheelchair ambulation:**

**Is client dependent on wheelchair for mobility and MRADL’s?** YES\_\_\_\_\_ NO\_\_\_\_\_

**If no, please explain:**

**Indicate the client’s transfer capability:**

**Is the client tube fed?**

**Dressing:**

**Describe other activities performed while in the wheelchair:**

**Environmental Assessment:**

**Describe where client resides**:

**Are ramps available in the home setting?**

**Is the home accessible to a wheelchair?**

**Describe the client’s educational/vocational setting:**

**Is the school accessible to a wheelchair?**

**Are there ramps available at the school?**

**If the client is in school, has a school therapist been involved in the assessment?**

**Name of school therapist:**

**Name of school:**

**Describe how the wheelchair will be transported:**

**Describe other types of equipment that will interface with the wheelchair:**

**Describe where the wheelchair will be stored:**

**Requested Equipment:**

**Describe client’s current seating system including mobility base:**

**Describe why current seating system is not meeting client’s needs:**

**Describe equipment requested:**

**Qty HCPCS Description Justification**

|  |  |  |  |
| --- | --- | --- | --- |
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**Describe the growth potential of equipment requested in number of years:**

**Describe any anticipated modifications/changes to the equipment within the next three years:**

**Therapist Name**

**Title**

**Phone**

**Employer Name**

**There is no financial relationship between the therapist (LCMP) completing this evaluation and the DME supplier.**

**Therapist’s Signature**:\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and concur with therapist evaluation.

Physician’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_