Patient Name: _____

Seating and Wheeled Mobility Clinical Evaluation

PATIENT INFORMATION:

Name: _____ **Referral Date**:_____ **Evaluation Date**:_____

Address: _____

Phone: _____ **Age**: _____ **Sex**: _____ **Height**:_____ **Weight**:_____

Physician: _____ **Referred by**: _____

Reason for referral: _____

Funding: _____ ID/SSN: _____

Primary caregiver: _____ **Relationship**: _____**Phone**: _____

Present at evaluation _____

_____

MEDICAL HISTORY (include ICD-9 codes)

Primary diagnosis: _____**ICD-9:** _____ **Onset:** _____

Other related diagnoses: _____

_____**ICD-9:**_____

Medical history: _____

_____

_____

_____

Recent change(s):_____

_____

_____

Prognosis: _____

Past surgeries (dates): _____

_____

Planned surgeries:_____

CURRENT SEATING AND MOBILITY EQUIPMENT

Ambulatory aid(s) (check all): ❒ Cane ❒ Crutches ❒ Standard walker ❒ Rollator

Mobility device(s) (check all): ❒ Manual wheelchair ❒ Power assist ❒ Scooter ❒ Power wheelchair

Primary mobility device: _____

Wheelchair: Age_____ Manufacturer: _____ Model name: _____ Size: _____

Seat cushion: Age_____ Manufacturer: _____ Model name: _____ Size: _____

Back support: Age _____ Manufacturer:_____ Model name: _____ Size: _____

Pertinent features**:**_____

_____

Hrs/day spent in the wheelchair: _____ **Funding source for current equipment:** _____

Reason for new equipment: _____

_____

_____

_____

PATIENT / CAREGIVER GOALS

_____

_____

_____

HOME, TRANSPORTATION AND ENVIRONMENT

Dwelling: ❒ Private home ❒ Apartment ❒ Independent living ❒ Assistive living ❒ Long-term care
❒ Mobile home ❒ Other _____ ❒ One level ❒ Multi-level

Narrowest doorway to access: _____ Entrance width: _____ Wheelchair accessible rooms: ❒ Yes ❒No

Comments: _____

Transportation: ❒ Car ❒ Adapted van ❒ Public transport ❒ School bus ❒ Other _____
Driving : ❒ Drives without adaptations ❒ Drives with adaptations ❒ Drives from wheelchair ❒ Does not drive

Access requirements: _____ Driving requirements: _____

Comments: _____

Environment:

Expected Place of Use	Full Time	Part Time	**Terrain Typically Encountered and Comments**
Home	❒	❒	_____
School	❒	❒	_____
Work	❒	❒	_____
Leisure/Recreation	❒	❒	_____
Other	❒	❒	_____

FUNCTIONAL AND PHYSICAL STATUS

Basic Activities of Daily Living

	Independent	**Needs Assist**	**Dependent**	**Describe Assistance, Devices Used and Issues**
Bathing	❒	❒	❒	_____
Dressing	❒	❒	❒	_____
Grooming	❒	❒	❒	_____
Eating	❒	❒	❒	_____
Food prep	❒	❒	❒	_____
Toileting	❒	❒	❒	_____
Bed mobility	❒	❒	❒	_____

Bladder: ❒ Continent ❒ Incontinent (type of management) _____

Bowels: ❒ Continent ❒ Incontinent (type of management) _____

Instrumental Activities of Daily Living

❒ Healthcare appointments ❒ Work ❒ Volunteer work ❒ School ❒ Shopping ❒ Parenting ❒ Banking

❒ Religious services ❒ Home and financial management ❒ Accessing facility dining room ❒ Family outings

❒ Others_____

Describe person's primary roles and responsibilities: _____

Activity level: ❒ Low ❒ Moderate ❒ High Describe: _____

Patient has caregiver assistance: ❒ No ❒ Yes; frequency, type:_____

Transfers:

	Independent	Needs,assist	Dependent,	Describe Assistance Needed and Issues
Bed:	❒	❒	❒	_____
Toilet:	❒	❒	❒	_____
Shower chair:	❒	❒	❒	_____
Wheelchair:	❒	❒	❒	(Type)_____

Type of transfer:_____ Problems with transfers: _____

Device: ❒None ❒ Cane ❒ Walker ❒ Sliding board ❒ Lift ❒ Other: _____

REVIEW OF SYSTEMS

Cardiac: ❒ WNL ❒ Compromised (describe)_____

_____

Respiratory: ❒ WNL ❒ Compromised (describe)_____

_____

Respiratory support: _____

Endurance: ❒ WNL ❒ Compromised (describe)_____

_____

Skin Integrity (**** record any pertinent ICD-9 codes on page one)***

❒ History of breakdown (Stages/ locations*): _____

_____

❒ Currently intact ❒ Current breakdown (Stages/locations*): _____

_____

Sensation: ❒ Normal ❒ Impaired (Location): _____

Mode of weight shift: _____

❒ Independent ❒ Dependent ❒ Needs assist (describe): _____

Describe effectiveness, duration, frequency: _____

_____

Patient Name: _____

Other risk factors for skin: _____

Pain: Location: _____ Intensity: _____

Describe (history, triggers, progression, interventions tried/ruled out): _____

_____

Cognition, Behavior, Perception

Memory: ❒ Intact ❒ Impaired (describe) _____
Learning: ❒ Intact ❒ Impaired (describe) _____
Judgment: ❒ Intact ❒ Impaired (describe) _____
Attention: ❒ Intact ❒ Impaired (describe) _____
Vision: ❒ Intact ❒ Impaired (describe) _____
Hearing: ❒ Intact ❒ Impaired (describe) _____
Perception: ❒ Intact ❒ Impaired (describe) _____
Communication: ❒ Intact ❒ Impaired (describe) _____

Comments: _____

POSTURAL EVALUATION *Please indicate if deformity is fixed (FX), partially flexible, (PF) or flexible (FL):*

Anterior/Posterior Pelvic Tilt **Cause / Severity**

❒ Neutral  ❒ Posterior  ❒ Anterior  ❒FX ❒PF ❒FL _____

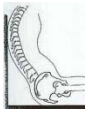
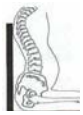
Pelvic Obliquity

❒Level  ❒ L lower  ❒R lower  ❒FX ❒PF ❒FL _____

Pevic Rotation

❒ Neutral  ❒ Right forward  ❒ Left forward  ❒FX ❒PL ❒FL _____

Trunk Anterior/Posterior Curve

❒ Normal  ❒ Kyphosis  ❒ Lordosis  ❒FX ❒PF ❒ FL _____

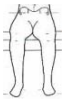
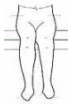
Trunk Lateral Lean/Scoliosis

❒ Midline  ❒ Convex left ❒ Left lean  ❒ Convex right ❒ Right lean  ❒ FX ❒ PF ❒ FL _____

Trunk Rotation

❒ Midline  ❒ Right forward  ❒ Left forward  ❒ FX ❒ PF ❒ FL _____

Lower Extremities

❒ Midline  ❒ Abduction ❒ R ❒ L  ❒ Adduction ❒ R ❒ L  ❒ FX ❒ PF ❒ FL _____

❒ Midline  ❒ Windswept right  ❒ Windswept left  ❒ FX ❒ PF ❒ FL _____

Head

❒ Midline ❒ Cervical flexion ❒ Cervical extension ❒ Rotated right ❒ FX ❒ PF ❒ FL _____

❒ Rotated left ❒ Right lateral flexion ❒ Left lateral flexion _____

Shoulders _____

Elevated ❒ R ❒ L Depressed ❒ R ❒ L ❒ FX ❒ PF ❒ FL _____

Protracted ❒ R ❒ L Retracted ❒ R ❒ L ❒ FX ❒ PF ❒ FL _____

How do postural abnormalities affect function/mobility?: _____

_____

_____

Balance:

	Independent	Needs assist	Dependent,	Describe
Static sitting	❒	❒	❒	_____
Dynamic sitting	❒	❒	❒	_____
Static standing	❒	❒	❒	_____
Dynamic standing	❒	❒	❒	_____

How do balance deficits affect function/mobility:_____

_____

Describe type, location, degree and results of any simulated support to assist posture _____

_____

_____

Muscle Strength: ***use scale of 0 – 5 (if more detailed analysis is required please add Manual Muscle Test sheet)***

LEFT		RIGHT	Comment on effect on function/mobility (i.e. muscular endurance)
	Shoulder		
	Elbow		
	Wrist		
	Hand		
	Hip		
	Knee		
	Ankle		

How do strength deficits affect function/mobility?: _____

_____

_____

Muscle Tone

❒ Normal (location): _____

❒ Hypertonic (location/ type): _____

❒ Hypotonic (location): _____

❒ Fluctuating (location): _____

Primitive reflexes (describe): _____

How does abnormal tone affect function/mobility?: _____

_____

_____

Range of Motion: ***document and describe deficits***

LEFT			**RIGHT**	
ACTIVE	**PASSIVE**		**ACTIVE**	**PASSIVE**
		Shoulder		
		Elbow		
		Wrist		
		Hand		
		Hip		
		Knee Extension*		
** with hip flexed to 90° and pelvis as neutral as possible to assess hamstring length. Check one:* ❒sitting ❒supine				
		Knee Flexion		
		Dorsiflexion		
		Plantarflexion		

How do ROM deficits affect function/mobility?: _____

_____

_____

Gross Motor Control:

Left UE: ❒ WNL ❒ Impaired (describe):_____

Right UE: ❒ WNL ❒ Impaired (describe):_____

Left LE: ❒ WNL ❒ Impaired (describe): _____

Right LE: ❒ WNL ❒ Impaired (describe): _____

Fine Motor Control:

Left UE: ❒ WNL ❒ Impaired (describe): _____

Right UE: ❒ WNL ❒ Impaired (describe): _____

How do motor control deficits affect function/mobility?:_____

_____

MOBILITY

Ambulation: ***For all questions below, describe assessments without device, with cane and with walker (specify). Include any orthotic/prosthetic devices used or indicate if needed***

Describe patient's current ambulatory ability (include assessment of speed, distance, assistance needed and gait pattern):

_____

_____

_____

Describe history and frequency of falls or other safety issues: _____

_____

Describe how long patient can stand / walk before needing to sit: _____

Describe why ambulatory device(s) is no longer or not adequate: _____

_____

_____

Manual Wheelchair Propulsion

Method of propulsion: ❒UEs ❒LEs ❒Both UEs and LEs ❒One UE, one LE (❒R ❒L) ❒ Dependent

If patient has current wheelchair, describe ability to propel (include distance, speed, stroke pattern, safety): _____

_____

_____

For all patients, describe results of trials in new / different wheelchair (include type, configuration, distance, speed, stroke pattern, safety): _____

_____

_____

Describe wheelchair skills and capacity

Current Wheelchair		Optimally Configured Wheelchair
	Level surfaces	
	Inclines	
	Mild environmental barriers*	
	Moderate environmental barriers**	
	Rough/challenging terrain	
	Rear wheel balancing (wheelies)	

*curb cuts, thresholds ** architectural barriers, curbs, potholes, non ADA compliant ramps, etc.

Describe wheelchair configuration needed to maximize function (e.g. specific seat width/depth, back height, seat to floor height, axle position, seat to back angle, tilt, power assist, etc.)_____

_____

Describe features of seat / back support and postural supports needed for functional mobility_____

_____

_____

Explain why the lower level MWC cannot be configured and/or will not meet patient's needs._____

_____

_____

Describe how recommended MWC will improve patient's ability to participate in ADLs and IADLs_____

_____

_____

Power Mobility

Is the patient able to utilize a POV? ❒ Yes ❒ No; If no, explain why. _____

_____

_____

What type of power wheelchair was trialed and what were the results? (include pertinent configuration and features):

_____

_____

Describe capacity for safe, maneuverable operation of a power wheelchair_____

_____

PWC method of operation: ❒ Standard joystick (❒ L ❒ R) ❒ Specialty joystick ❒ Alternative control

Describe type of input device and location: _____

_____

Is there a medical need for power seat functions? ❒ No ❒ Yes (describe): _____

_____

Describe environments for typical daily activities ❒ Flat, level surfaces ❒ Mildly uneven ❒ Moderately uneven

❒ Rough ❒ Inclines ❒ Inclement weather ❒ Other _____

Appropriate type of chair: ❒ Group 1 ❒ Group 2 ❒ Group 3 ❒ Group 4 ❒ Group 5

Explain: _____

_____

Describe features of seat / back support and postural supports needed for functional mobility_____

_____

_____

Explain why the lower level PWC cannot be configured and/or will not meet patient's needs._____

_____

_____

Describe how recommended PWC will improve patient's ability to participate in ADLs and IADLs_____

_____

_____

ASSESSMENT

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____

PLAN

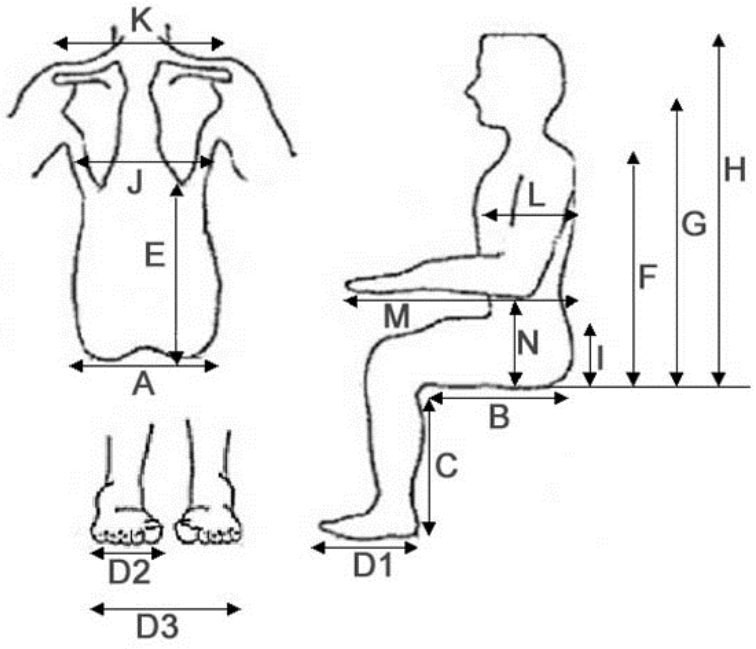
_____

_____

_____

_____

PATIENT MEASUREMENTS



A _____ Hip width
B _____ R Sacrum to popliteal fossa
B _____ L Sacrum to popliteal fossa
C _____ R Knee to heel
C _____ L Knee to heel
D1 _____ R Foot length
D1 _____ L Foot length
D2 _____ R Foot width
D2 _____ L Foot width
D3 _____ Feet width
E _____ R inferior angle of scapula
E _____ L inferior angle of scapula

F _____ R Shoulder height
F _____ L Shoulder height
G _____ Occiput height
H _____ Top of head
I _____ PSIS of pelvis
J _____ Chest width
K _____ Shoulder width
L _____ Trunk depth
M _____ R Forearm length
M _____ L Forearm length
N _____ Elbow height

Measurements taken by: _____

Date: _____

Note: All measurements are actual patient anatomical measurements

Patient Name: _____

PROBLEM	PRODUCT FEATURE AND JUSTIFICATION

Patient Name: _____

PROBLEM	PRODUCT FEATURE AND JUSTIFICATION

ADDITIONAL NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PT / OT Name (print): _____ Phone: _____

Facility: _____

PT/OT Signature**:** _____ Date**:** _____

I have read and concur with the above evaluation and recommendations.

Physician Name (print):_____NPI:_____

Facility: _____ Phone: _____

Physician Signature: _____ Date:_____

Date of physician's face-to-face visit with patient (if different): _____

ATP (supplier) Name (Print): _____Phone_____

ATP (supplier) Signature:_____ Date:_____

Company: _____Phone_____