

Seating/Mobility Evaluation

To be completed by **Physiatrist or Physical/Occupational Therapist**
In Association With **Mobility Device Specialist**

PATIENT INFORMATION:

Name:	DOB:	Sex:	Evaluation Date:
Address:	Physician:		This form will serve as the LMN for the following Suppliers: Primary: Contact Name: Phone #:
	Mobility Device Therapist: License #: Phone #:		
Phone #:	Mobility Device Specialist: Title: Phone:		Rehabilitation Engineering Program or 2nd Supplier: Contact Name: Phone #:
Spouse/Parent/Caregiver/Guardian Name: Relationship: Phone #:	Primary Therapist: Phone #: Insurance/Payer: Patient Recipient #:		
Reason for Referral:			
Patient Goals:			
Caregiver Goals and Specific Limitations that May Effect Care:			

MEDICAL HISTORY:

Primary Diagnosis:		Onset:	
Secondary Diagnosis:			
<input type="checkbox"/> Progressive Disease	Relevant Past and Future Surgeries:		
Height:	Weight:	Describe Changes Past 2-5 years-Include Seating Measurements If Relevant:	
Cardio Status:	Functional Limitations:		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Severely Impaired <input type="checkbox"/> NA			
Respiratory Status:	Functional Limitations:		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Severely Impaired <input type="checkbox"/> NA			
Orthotics	Amputee <input type="checkbox"/> Yes <input type="checkbox"/> No		

HOME ENVIRONMENT

<input type="checkbox"/> Home <input type="checkbox"/> Condo/Town Home <input type="checkbox"/> Apartment <input type="checkbox"/> Asst Living <input type="checkbox"/> Own <input type="checkbox"/> Rent	
<input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Others (Who?)	Hours with caregiver:
<input type="checkbox"/> Home is Accessible to Equipment Storage of Wheelchair: <input type="checkbox"/> In Home <input type="checkbox"/> Other Stairs: <input type="checkbox"/> Yes <input type="checkbox"/> No Comment:(Describe management of equipment if stairs present - Describe security of Storage if Other is Checked)	

COMMUNITY ADL:

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	
Where is W/C Stored During Transport ?	<input type="checkbox"/> Tie Downs
<input type="checkbox"/> Self Driver	Drive While in Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment: Specific Requirements Pertaining to Mobility:	
School: Specific Requirements Pertaining to Mobility:	
Other:	

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> NA Comments:
Visual Acuity Is Adequate For Safe Wheelchair Operation: <input type="radio"/> Yes <input type="radio"/> No
Processing Skills are Adequate for Safe Wheelchair Operation <input type="radio"/> Yes <input type="radio"/> No
Comments - Describe Limitations:

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 <input type="checkbox"/> Uses An Augmetative Communication Device Manufacturer/Model:
AAC Mount Needed:

SENSATION and SKIN ISSUES

<p>Sensation <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hyposensate <input type="checkbox"/> Hypersensate <input type="checkbox"/> Defensiveness Level of sensation:</p>	<p>Pressure Relief Able to perform Effective Pressure Relief: <input type="checkbox"/> Yes <input type="checkbox"/> No Method: If not, Why?</p>	
<p>Skin Issues/Skin Integrity Current Skin Issues <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Intact <input type="checkbox"/> Red Area <input type="checkbox"/> Open Area <input type="checkbox"/> Scar Tissue <input type="checkbox"/> At Risk from Prolonged Sitting Where</p>	<p>History of Skin Issues <input type="checkbox"/> Yes <input type="checkbox"/> No Where When</p>	<p>Hx of Skin Flap Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No Where When</p>
<p>Complaint of Pain: (Describe Location, Severity (Scale 1-10), Acute or Chronic, And How it Interferes With Ability To Operate Equip.)</p>		

ADL STATUS (In Reference to Wheelchair Use):

	Indep	Assist	Unable	Indep with Equip	Not Assessed	Comments
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe Oral Motor Skills
Grooming/Hygiene bipap_adl_status_grooming_hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IADLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Mngmnt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						Comments:
Bladder Mngmnt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						Comments:

CURRENT SEATING/MOBILITY

Current Mobility Base: None Dependent Dependent with Tilt Manual Scooter Power

Type of Control:

Manufacturer: Pediatric Adult **Size:** **Model:** **Serial #;**
 Color: Age:

Current Condition of Mobility Base:

Current Seating System: **Age of Seating System:**

COMPONENT	MANUFACTURER/CONDITION
Seat Base	
Cushion	
Back	
Lateral Trunk Supports	
Thigh Support	
Knee Support	
Foot Support	
Foot Strap	
Head Support	
Pelvic Stabilization	
Anterior Chest/Shoulder Support	
UE Support	
Other (Tilt/Recline, etc)	
When Relevant:	Overall Seat Height: Overall W/C Length: Overall W/C Width:
Describe Posture in Present Seating System:	
Number of Hours/Day Spent in Wheelchair ?	

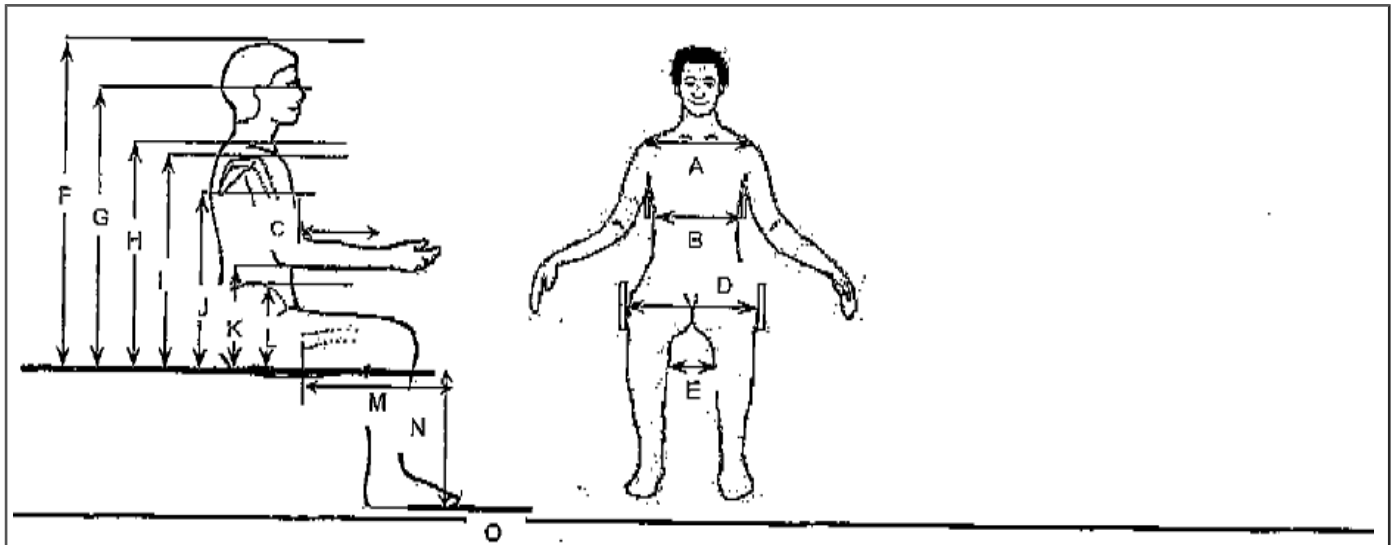
WHEELCHAIR SKILLS: (Shown by Trial) PT. IS TOTALLY DEPENDENT FOR MOBILITY YES ? NO ?

	Indep	Assist	Dependent/Unable	N/A	Comments
Bed ? W/C Chair Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
w/c ? Commodo Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Manual w/c Propulsion:	<input type="checkbox"/> UE or LE Strength and Endurance Sufficient to Participate in ADLs Using Manual Wheelchair				Arm: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Foot: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Operate Scooter	<input type="checkbox"/> Strength, Hand Grip, Balance, Transfer Appropriate for Use. <input type="checkbox"/> Living Environment Appropriate for Scooter Use.				
Operate Power W/C: Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance
Operate Power W/C: W/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance

MOBILITY/BALANCE:

Balance		Transfers	Ambulation
Sitting Balance	Standing Balance	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent
<input type="checkbox"/> WFL	<input type="checkbox"/> WFL	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Ambulates with Asst
<input type="checkbox"/> Uses UE for Balance in Sitting	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Mod Asst	<input type="checkbox"/> Ambulates with Device
<input type="checkbox"/> Min Assist	<input type="checkbox"/> Mod Assist	<input type="checkbox"/> Max Assist	<input type="checkbox"/> Indep. Short Distance Only
<input checked="" type="checkbox"/> Mod Assist	<input type="checkbox"/> Max Assist	<input type="checkbox"/> Dependent	<input type="checkbox"/> Unable to Ambulate
<input type="checkbox"/> Max Assist	<input type="checkbox"/> Unable	<input type="checkbox"/> Sliding Board	
<input type="checkbox"/> Unable		<input type="checkbox"/> Lift/Sling Required	
Comments:			

MAT EVALUATION:



Measurements in Sitting	Left	Right
A: Shoulder Width		H: Seat to Top of Shoulder
B: Chest Width		I: Acromium Process (Tip of Shoulder)
C: Chest Depth (Front - Back)		J: Inferior Angle of Scapula
D: Hip Width		K: Seat to Elbow
E: Between Knees		L: Seat to Iliac Crest
F: Top of Head		M: Upper leg length
G: Occiput		N: Lower leg length
++: Overall width (asymmetrical width for windswept legs or scoliotic posture)		O: Foot Length









Additional Comments:

Hamstring flexibility:

Pelvis to Thigh angle accommodate greater than 90 **Thigh to calf angle** accommodate less than 90

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

EXPLAIN WHY PATIENT IS NON-AMBULATORY:

Posture			Comments	
PELVIS	<p>Anterior / Posterior</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other</p>	<p>Obliquity</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> L elev</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other</p>	<p>Rotation-Pelvis</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> Right Anterior <input type="checkbox"/> Left Anterior</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other</p>	
	<p>Anterior / Posterior</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> Thoracic Kyphosis <input type="checkbox"/> Lumbar Lordosis</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other</p>	<p>Left Right</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right</p> <p><input type="checkbox"/> c-curve <input type="checkbox"/> s-curve <input type="checkbox"/> multiple <input type="checkbox"/> Fixed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other</p>	<p>Rotation-Shoulders and upper trunk</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> Left-anterior <input type="checkbox"/> Right-anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other</p>	
<p>Describe LE Neurological Influence/Tone:</p>				
HIPS	<p>Position</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> Abduct <input type="checkbox"/> Adduct</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible</p>	<p>Windswept</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible <input type="checkbox"/> Other</p>	<p>Hip Flexion/Extension Limitations:</p> <p>Hip Internal/External Range of motion Limitation:</p>	
	<p>Knee R.O.M</p> <p>Left Right</p> <p><input type="checkbox"/> WFL <input type="checkbox"/> WFL</p> <p><input type="checkbox"/> Limitations <input type="checkbox"/> Limitations</p>		<p>Foot Positioning</p> <p><input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>ROM Concerns:</p> <p>Dorsi-Flexed <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Plantar Flexed <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Inversion <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Eversion <input type="checkbox"/> L <input type="checkbox"/> R</p>	
HEAD & NECK	<p><input type="checkbox"/> Functional</p> <p><input type="checkbox"/> Flexed <input type="checkbox"/> Extended</p> <p><input type="checkbox"/> Rotated L <input type="checkbox"/> Lat Flexed L</p> <p><input type="checkbox"/> Rotated R <input type="checkbox"/> Lat Flexed R</p> <p><input type="checkbox"/> Cervical Hyperexlesion</p>	<p><input type="checkbox"/> Good Head Control</p> <p><input type="checkbox"/> Adequate Head Control</p> <p><input type="checkbox"/> Limited Head Control</p> <p><input type="checkbox"/> Absent Head Control</p>	<p>Describe Tone/Movement of head and Neck:</p>	

UPPER EXTR EMITY	SHOULDERS		R.O.M. for Upper Extremity <input type="checkbox"/> WNL <input type="checkbox"/> WFL Limitations: UE Strength (X/5) <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Concerns	Describe Tone/Movement of UE:
	Left	Right		
<input type="checkbox"/> Functional	<input type="checkbox"/> Functional	<input type="checkbox"/> elev / dep	<input type="checkbox"/> elev / dep	
<input type="checkbox"/> pro-retract	<input type="checkbox"/> pro-retract	<input type="checkbox"/> subluxed	<input type="checkbox"/> subluxed	
	ELBOWS		R.O.M. Strength (X/5) Strength concerns:	
	Left	Right		
WRIST & HAND	Left	Right	Strength / Dexterity: (X/5)	
	<input type="checkbox"/> Fisting			

Goals for Wheelchair Mobility

- Independence with mobility in the home and mobility related ADLs (MRADLs) in the community.
- Independence with MRADLs in the community
- Provide dependent mobility
- Provide recline
- Provide tilt

Goals for Seating System

- Optimize pressure distribution
- Provide support needed to facilitate function or safety
- Provide corrective forces to assist with maintaining or improving posture
- Accommodate client's posture: current seated postures and positions are not flexible or will not tolerate corrective forces
- Client to be independent with relieving pressure in the wheelchair
- Enhance physiological function such as breathing, swallowing, digestion

Equipment Trial: (Must be of adequate duration to demonstrate independence for patient with previous dependent mobility.)

Describe Duration and Location of Trial:

Patient Demonstrated Ability To Use Equipment Safely & Efficiently Yes No Comments:

State why other equipment was unsuccessful:

RECOMMENDATIONS & JUSTIFICATION (Lowest Appropriate Group Must Be Recommended)

MOBILITY BASE	JUSTIFICATION	
Mfg: _____ Model: _____ Seat Width: _____ Seat Depth: _____ Can Be Grown To: (Must Complete) Seat Width: _____ Seat Depth: _____	<input type="checkbox"/> Provide transport from point A to B <input type="checkbox"/> Promote Indep mobility <input type="checkbox"/> Is not a safe, functional ambulator <input type="checkbox"/> walker or cane, inadequate	<input type="checkbox"/> Non-standard width/depth necessary to accommodate anatomical measurement <input type="checkbox"/> Other
<input type="checkbox"/> Manual Mobility Base	<input type="checkbox"/> Non-functional ambulator	
<input type="checkbox"/> Scooter/POV	<input type="checkbox"/> Can safely operate <input type="checkbox"/> has adequate trunk stability <input type="checkbox"/> Can safely transfer <input type="checkbox"/> Can not functionally propel manual wheelchair	
<input type="checkbox"/> Power Mobility Base	<input type="checkbox"/> Can not functionally propel manual wheelchair <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Can not functionally and safely operate scooter/POV	
<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"/> Indep mobility is not a goal at this time
Reasons This Particular WC was chosen for Patient ? 		
Why isn't a Lower Group Appropriate for Patient ? 		
Tilt Base or added ? Forward ? Backward ? Powered tilt on powered chair ? Powered tilt on manual chair ? Manual tilt on manual base	<input type="checkbox"/> change position against gravitational force on head and shoulders <input type="checkbox"/> change position for pressure relief/can not weight shift <input type="checkbox"/> transfers	<input type="checkbox"/> management of tone <input type="checkbox"/> rest periods <input type="checkbox"/> control edema <input type="checkbox"/> facilitate postural control <input type="checkbox"/> Other
Recline ? Power recline on power base ? Manual recline on manual base	<input type="checkbox"/> accommodate femur to back angle <input type="checkbox"/> bring to full recline for ADL care <input type="checkbox"/> change position for pressure relief/can not weight shift	<input type="checkbox"/> rest periods <input type="checkbox"/> repositioning for transfers or clothing / diaper / catheter changes <input type="checkbox"/> head positioning
<input type="checkbox"/> Transportation tie-down option	<input type="checkbox"/> To provide crash tested tie down brackets	
Elevator on Mobility Base ? Wheelchair ? Scooter	<input type="checkbox"/> increase indep in transfers <input type="checkbox"/> increase indep in ADLs	<input type="checkbox"/> raise height for communication at standing level <input type="checkbox"/> Other
Push handles ? extended ? angle adjustable ? 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
Lighter weight required	<input type="checkbox"/> Self propulsion <input type="checkbox"/> lifting	<input type="checkbox"/> Other
Heavy Duty required	<input type="checkbox"/> user weight greater than 250 pounds <input type="checkbox"/> extreme tone <input type="checkbox"/> over active movement	<input type="checkbox"/> broken frame on previous chair <input type="checkbox"/> multiple seat functions <input type="checkbox"/> Other
Specific Seat height required Floor to seat height	<input type="checkbox"/> Foot Propulsion <input type="checkbox"/> transfers <input type="checkbox"/> accommodation of leg length	<input type="checkbox"/> access to table or desk top <input type="checkbox"/>

MOBILITY BASE	JUSTIFICATION	
Rear wheel placement/Axle adjustability ? None ? semi adjustable ? fully adjustable	<input type="checkbox"/> Improved UE access to wheels <input type="checkbox"/> Improved stability <input type="checkbox"/> changing angle in space for improvement of postural stability	<input type="checkbox"/> 1-arm drive access <input type="checkbox"/> amputee placement <input type="checkbox"/> Other
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"/> Other
POWER WHEELCHAIR CONTROLS <input type="checkbox"/> Proportional Type: Body Parts: <input type="radio"/> Left <input type="radio"/> Right <input type="checkbox"/> Non-Proportional/switches Type: Body Parts: Upgraded Electronics <input type="checkbox"/> Other <input type="checkbox"/> Display box <input type="checkbox"/> Digital interface electronics <input type="checkbox"/> ASL Head Array <input type="checkbox"/> Sip and puff tubing kit <input type="checkbox"/> Upgraded tracking electronics <input type="checkbox"/> Safety Reset Switches <input type="checkbox"/> Single or Multiple Actuator Control Module	<input type="checkbox"/> Provides access for controlling wheelchair <input type="checkbox"/> lacks motor control to operate proportional drive control <input type="checkbox"/> Unable to understand proportional controls <input type="checkbox"/> Programming for accurate control <input type="checkbox"/> progressive Disease/changing condition <input type="checkbox"/> Needed in order to operate power/tilt through joystick control <input type="checkbox"/> Allows user to see in which mode and drive the wheelchair is set; necessary for alternative controls <input type="checkbox"/> Allows w/c to operate when using alternative drive controls <input type="checkbox"/> Allows client to operate wheelchair through switches placed in tri-panel headrest <input type="checkbox"/> needed to operate sip and puff drive controls <input type="checkbox"/> increase safety when driving <input type="checkbox"/> correct tracking when on uneven surfaces <input type="checkbox"/> Used to change modes and stop the wheelchair when driving in latch mode <input type="checkbox"/> Allow the client to operate the power seat function(s) through the joystick control	If Expandable Controller Recommended Provide Additional Narrative In space At End Of Form re Why Patient Requires Expandable Controller vs. Non-Expandable Controller <input type="checkbox"/> Non-proportional drive control needed (Explain)
<input type="checkbox"/> Mount for switches or joystick	<input type="checkbox"/> attaches switches to w/c <input type="checkbox"/> swing away for access or transfers	<input type="checkbox"/> midline for optimal placement <input type="checkbox"/> provides for consistent access
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"/> Other
Battery	<input type="checkbox"/> power motor on wheelchair	
Charger	<input type="checkbox"/> charge battery for wheelchair	
Push rim active assist	<input type="checkbox"/> enable propulsion of manual wheelchair on sloped terrain	<input type="checkbox"/> enable propulsion of manual wheelchair for distance
Hangers/Leg rests <input type="checkbox"/> 60 <input type="checkbox"/> 70 <input type="checkbox"/> 90 <input type="checkbox"/> elevating <input type="checkbox"/> heavy duty <input type="checkbox"/> articulating <input type="checkbox"/> fixed <input type="checkbox"/> lift off <input type="checkbox"/> swing away <input type="checkbox"/> rotational hanger brackets <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"/> accommodate to hamstring tightness <input type="checkbox"/> elevate legs during recline <input type="checkbox"/> provide change in position for les <input type="checkbox"/> Provide LE Support <input type="checkbox"/> maintain placement of feet on footplate	<input type="checkbox"/> durability <input type="checkbox"/> enable transfers <input type="checkbox"/> decrease edema <input type="checkbox"/> Accommodate lower leg length <input type="checkbox"/> Other

Foot support <input type="checkbox"/> adjustable Footplate <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> flip up <input type="checkbox"/> depth/angle adjustable	<input type="checkbox"/> Provide foot Support <input type="checkbox"/> accommodate to ankie ROM <input type="checkbox"/> allow foot to go under wheelchair base	<input type="checkbox"/> transfers <input type="checkbox"/> Other
Armrests <input type="checkbox"/> fixed <input type="checkbox"/> adjustable height <input type="checkbox"/> removable <input type="checkbox"/> swing away <input type="checkbox"/> flip back <input type="checkbox"/> reclining <input type="checkbox"/> full length pads <input type="checkbox"/> desk <input type="checkbox"/> pads tubular	<input type="checkbox"/> Provide Support with elbow at 90 <input type="checkbox"/> provide support for w/c tray <input type="checkbox"/> changes of height/angles for variable activities	<input type="checkbox"/> remove for transfers <input type="checkbox"/> allow to come closer to table top <input type="checkbox"/> remove for access to tables <input type="checkbox"/> Other
Side guards	<input type="checkbox"/> prevent clothing getting caught in wheel or becoming soiled	
Wheel size: Wheel Style: <input type="checkbox"/> mag <input type="checkbox"/> spokes <input type="checkbox"/> Other	<input type="checkbox"/> increase access to wheel <input type="checkbox"/> allow for seating system to fit on base	<input type="checkbox"/> increase propulsion ability <input type="checkbox"/> maintenance <input type="checkbox"/>
Quick Release Wheels	<input type="checkbox"/> allows wheels to be removed to decrease width of w/c for storage	<input type="checkbox"/> decrease weight for lifting <input type="checkbox"/> Other
Wheels rims/ hand rims <input type="checkbox"/> metal <input type="checkbox"/> plastic coated <input type="checkbox"/> vertical projections <input type="checkbox"/> oblique projections	<input type="checkbox"/> provide ability to propel manual wheelchair	<input type="checkbox"/> increase self-propulsion with hand weakness/decreased grasp
Tires <input type="checkbox"/> pneumatic <input type="checkbox"/> flat free inserts <input type="checkbox"/> solid	<input type="checkbox"/> decrease maintenance <input type="checkbox"/> prevent frequent flats <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"/> Other
Caster Housing: Caster Size: Style:	<input type="checkbox"/> maneuverability <input type="checkbox"/> stability of wheelchair <input type="checkbox"/> increase shock absorbency <input type="checkbox"/> durability <input type="checkbox"/> maintenance <input type="checkbox"/> angle adjustment for posture	<input type="checkbox"/> decrease pain from road shock <input type="checkbox"/> decrease spasms from road shock <input type="checkbox"/> allows for feet to come under wheelchair base <input type="checkbox"/> allows change in seat to floor height <input type="checkbox"/>
Shock absorbers	<input type="checkbox"/> decrease vibration	<input type="checkbox"/> provide smoother ride over rough terrain
Spoke Protector	<input type="checkbox"/> prevent hands from getting caught in spokes	<input type="checkbox"/> Other
One armed device <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> enable propulsion of manual wheelchair with one arm	<input type="checkbox"/> Other
Anti-tippers	<input type="checkbox"/> prevent wheelchair from tipping backward	<input type="checkbox"/>
Amputee adapter <input type="checkbox"/> Crutch/cane holder <input type="checkbox"/> Oxygen Cylinder holder <input type="checkbox"/> IV hanger	<input type="checkbox"/> provide support for stump/residual extremity <input type="checkbox"/> stabilize accessory on wheelchair	
Brake/Wheel lock extension <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> increase indep in applying wheel locks
Other:		
Other:		

SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manuf/mod/size	Justification	
Seat Cushion		<input type="checkbox"/> accommodate impaired sensation <input type="checkbox"/> decubitus ulcers present <input type="checkbox"/> prevent pelvic extension <input type="checkbox"/> low maintenance	<input type="checkbox"/> stabilize pelvis <input type="checkbox"/> accommodate obliquity <input type="checkbox"/> accommodate multiple deformity <input type="checkbox"/> neutralize LE <input type="checkbox"/> increase pressure distribution <input type="checkbox"/>
Seat Wedge		<input type="checkbox"/> accommodate ROM	<input type="checkbox"/> Provide increased aggressiveness of seat shape to decrease sliding down in the seat
Cover Replacement		<input type="checkbox"/> protect back or seat cushion	<input type="checkbox"/> Other
Mounting hardware lateral trunk supports headrest medial thigh support back seat	Fixed swing away for:	<input type="checkbox"/> attach seat platform/cushion to w/c frame <input type="checkbox"/> attach back cushion to w/c frame	<input type="checkbox"/> mount headrest <input type="checkbox"/> swing medial thigh support away <input type="checkbox"/> swing lateral supports away for transfers
Seat Board Back Board		<input type="checkbox"/> support cushion to prevent hammocking	<input type="checkbox"/> allows attachment of cushion to mobility base
Back		<input type="checkbox"/> provide lateral trunk support <input type="checkbox"/> accommodate deformity <input type="checkbox"/> accommodate or decrease tone <input type="checkbox"/> facilitate tone	<input type="checkbox"/> provide posterior trunk support <input type="checkbox"/> provide Lumbar/sacral support <input type="checkbox"/> support trunk in midline <input type="checkbox"/> Other
Lateral Pelvic/thigh support		<input type="checkbox"/> pelvis in neutral <input type="checkbox"/> accommodate pelvis <input type="checkbox"/> position upper legs	<input type="checkbox"/> accommodate tone <input type="checkbox"/> removable for transfers <input type="checkbox"/>
Medial knee Support		<input type="checkbox"/> decrease adduction <input type="checkbox"/> accommodate ROM	<input type="checkbox"/> remove for transfers <input type="checkbox"/> alignment
Foot Support		<input type="checkbox"/> position foot <input type="checkbox"/> accommodate deformity	<input type="checkbox"/> stability <input type="checkbox"/> decrease tone <input type="checkbox"/> control position
Ankle strap/heel loops		<input type="checkbox"/> support foot on foot support <input type="checkbox"/> decrease extraneous	<input type="checkbox"/> provide input to heel <input type="checkbox"/> protect foot
Lateral trunk Supports	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> decrease lateral trunk leaning <input type="checkbox"/> accom asymmetry <input type="checkbox"/> contour for increased contact	<input type="checkbox"/> safety <input type="checkbox"/> control of tone <input type="checkbox"/> Other
Anterior chest strap, vest, or shoulder retractors		<input type="checkbox"/> decrease forward movement of shoulder <input type="checkbox"/> accommodation of TLSO decrease forward movement of trunk	<input type="checkbox"/> added abdominal support <input type="checkbox"/> alignment <input type="checkbox"/> assistance with shoulder control <input type="checkbox"/> decrease shoulder elevation <input type="checkbox"/> Other
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"/> improve respiration <input type="checkbox"/> placement of switches <input type="checkbox"/> safety <input type="checkbox"/> accommodate ROM <input type="checkbox"/> accommodate tone <input type="checkbox"/> improve visual orientation

Neck Support		<input type="checkbox"/> decrease neck rotation	<input type="checkbox"/> decrease forward neck flexion
Upper Extremity Support Arm trough Posterior hand support 1/2 tray full tray full tray	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> decrease edema <input type="checkbox"/> decrease subluxation <input type="checkbox"/> control tone <input type="checkbox"/> provide work surface <input type="checkbox"/> placement for AAC/Computer/EADL	<input type="checkbox"/> decrease gravitational pull on shoulders <input type="checkbox"/> provide midline positioning <input type="checkbox"/> provide support to increase UE functions <input type="checkbox"/> provide hand support in natural position
Pelvic Positioner		<input type="checkbox"/> stabilize tone <input type="checkbox"/> decrease falling out of chair/will not decrease potential for sliding due to pelvic titling <input type="checkbox"/> Prevent excessive rotation	<input type="checkbox"/> pad for protection over boney prominence <input type="checkbox"/> prominence comfort <input type="checkbox"/> special pull angle to control rotation <input type="checkbox"/> Other
Bag or pouch		Holds: <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"/> Other
Other:			

ADDITIONAL NARRATIVE DOCUMENTATION (MUST BE LEGIBLE)

SIGNATURES SHOWN BELOW MUST BE COMPLETED!

Patient/Client/Caregiver/ Guardian Signature:		Date:
Therapist Name/Title Printed:		
Therapist's Signature		Date:
Supplier's Rep/Title Printed		
Supplier's Rep Signature:		Date:

This is to certify that I, the above signed therapist have the following affiliations:

- This DME Provider
- Manufacturer of Recommended Equipment
- Patient's Long Term Care Facility
- None of the above

My signature below certifies that I agree with the recommendations above and order the equipment shown on the provider's itemized price list.

Physician's Signature:

Date:

Need patients chart notes.