

Seating/Mobility Evaluation

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

Total Time _____
Eval 97001 or 97003 (min) _____
WC Assess 97542 minutes _____

PATIENT INFORMATION

Name	DOB	Sex	Evaluation Date
Address	Physician		Supplier Information
	MD Phone		
Phone	Therapist		
Spouse/Parent/Caregiver Name	Primary Insurance Payor		Contact Person
	Policy #		
Phone Number	Secondary Ins. Payor		Phone
	Policy #		

MEDICAL HISTORY

Diagnosis	ICD10 Code	Primary Diagnosis Onset	ICD10 Code	Diagnosis
	ICD10 Code	Diagnosis	ICD10 Code	Diagnosis
Height	Weight	Explain recent changes or Trends in Weight		

Pertinent Medical and Functional History

Cardio Pulmonary Functional Limitations Status

Intact Impaired Severely Impaired

CURRENT MRADL STATUS (with present Mobility Assistive Equipment)

	Indep	Assist	Unable	Indep With Equip	Not assessed	Comments/Equipment
Dressing						
Eating						
Grooming/Hygiene						
Toileting						
Bathing						
IADLS						
Bowel Mngmnt <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						
Bladder Mngmnt <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						

Patient Name

STRENGTH/RANGE OF MOTION

	R Strength	L Strength	R AROM	L AROM
Sh. Flex.				
Elbow Flex.				
Elbow Ext.				
Wrist				
Hip Flex.				
Knee Flex/Ext				
Ankle DF/PF				
Grip				

Patient has sufficient strength and range to ambulate and participate in MRADLs.

Patient does not have sufficient strength and range to ambulate and participate in MRADLs.

Patient has sufficient strength and range to propel a manual W/C and participate in MRADLs.

Patient does not have sufficient strength and range to propel a manual W/C and participate in MRADLs.

Patient has sufficient strength and range to operate a POV and participate in MRADLs.

Patient does not have sufficient strength and range to operate a POV and participate in MRADLs.

Comments

BALANCE/ENDURANCE

Sitting Balance	WFL
Standing Balance	WFL
Falls/Injuries	
Endurance	WFL

Patient has sufficient balance and/or endurance to ambulate and participate in MRADLs.

Patient does not have sufficient balance and/or endurance to ambulate and participate in MRADLs.

Patient has sufficient balance and/or endurance to propel a manual W/C and participate in MRADLs.

Patient does not have sufficient balance and/or endurance to propel a manual W/C and participate in MRADLs.

Patient has sufficient balance and/or endurance to operate a POV and participate in MRADLs.

Patient does not have sufficient balance and/or endurance to operate a POV and participate in MRADLs.

Comments

TRANSFERS AND AMBULATION

Transfers (Method, Assistance, Device)	
Ambulation (Distance, Assistance, Device)	

EXPLAIN WHY PROPERLY FITTED CANE, CRUTCHES or WALKER CANNOT SUFFICIENTLY RESOLVE MOBILITY DEFICIT RELATED to BATHING, DRESSING, TOILETING

Patient Name

VISUAL/PERCEPTUAL and SENSORY PROCESSING SKILLS

- Patient has sufficient vision, perception and/or motor planning to operate MAE and participate in MRADLs.
- Patient does not have sufficient vision, perception and/or motor planning to operate MAE and participate in MRADLs.

SKIN STATUS and RISK

Sensation / Wound Status / Wound History / Ability and Limitations to Perform Pressure Relief / Pain / Skin Risk

- Skin Status and Risk Assessment does not warrant intervention via this mobility system's recommendations.

CURRENT SEATING / MOBILITY

Current Mobility Base CURRENT MRADL STATUS (with present Mobility Assistive Equipment)

- None Stroller Manual Manual with Tilt Manual with recline Scooter
- Power Power w/tilt Power w/recline Power w/tilt & recline w/seat elevator w/stand

Type of Control

Manufacturer	Model	Age
Condition of Current Mobility Base		
Problems with Current Mobility Base		
Current Seating		
Seat Width/Depth		
STF-Pan/Cushion		
Cushion		
Pelvic Support		
Thigh Support		
Knee Support		
Foot Support		
Foot Strap/Heel Loop		
Back		
Mounting Hardware		
Lateral Trunk Supports		
Anterior Chest / Shoulder Support		
Head Support		
Mounting Hardware		
UE Support		
Mounting Hardware		
Other		
Other		

HOME ENVIRONMENT

- House Condo/Town Home Apartment Asst Living LTCF SNF Own Rent
- Lives Alone Lives Alone / Caregiver Asst Lives with Caregiver Hours Home Alone _____
- Home is Accessible to Equipment Stairs Yes No Ramp Yes No

Comments:

Patient Name

COMMUNITY ADL

How will device be transported? N/A Sitting in Wheelchair? Yes No Self Driver? Yes No

Community Activities/Needs:

WHEELCHAIR SKILLS (Shown by Trial)

Equipment Trials Specifics (Timeliness, Pain, Posture, Effectiveness, Function and Why Less Costly Equipment Ruled Out)

High Strength Lightweight Ultra Lightweight Safe Functional Distance _____ MWC Not Tried
Arm Left Right Foot Left Right **EXPLAIN WHY OPTIMALLY CONFIGURED MANUAL WHEELCHAIR CANNOT SUFFICIENTLY RESOLVE MOBILITY DEFICIT AS IT RELATES TO MRADL's** N/A

P.O.V. (Scooter) Not Tried due to: Strength, hand grip, balance, control or transfers are not appropriate for scooter use.
 Living environment is not appropriate for scooter use.

Power Wheelchair – Patient is Safe, Independent, Willing, Capable Mobility Deficit related to Toileting
 Bathing Dressing is sufficiently resolved with PWC; N/A

Goals for Wheelchair Seating and Mobility

- Increased level of independence with mobility in the home with mobility related ADLs (MRADLs)
- Increased level of independence with community mobility
- Dependent mobility
- Patient Caregiver must be able to load wheelchair in _____
- Provide recline Tilt Seat Elevation Lower Extremity Elevation
- Optimize pressure distribution
- Increase sitting tolerance to tolerate greater than _____ hours per day
- Provide postural support needed to facilitate function or safety
- Provide corrective forces cease or correct destructive postural tendencies
- 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 and/or elimination
- Other

Name:

RIC MR#:







Insurance/recipient #

Orientation of Supports

Accommodate	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both sides	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both sides
Pelvis to Thigh Angle	<input type="checkbox"/> Greater than 90	<input type="checkbox"/> Less Than 90
Thigh to Calf Angle	<input type="checkbox"/> Greater than 90	<input type="checkbox"/> Less than 90

Explain why patient is non-ambulatory:

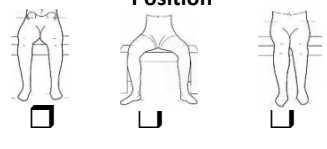

CHEAT SHEET

POSTURE: (MAT EVALUATION)				COMMENTS:
PELVIS	Tendency: Anterior/Posterior	Obliquity	Rotation-Pelvis	Tonal Influence Pelvis: <input type="checkbox"/> Paralysis <input type="checkbox"/> Flaccid <input type="checkbox"/> Low Tone <input type="checkbox"/> High Tone <input type="checkbox"/> Spasticity <input type="checkbox"/> Dystonia <input type="checkbox"/> Pelvic Thrust <input type="checkbox"/> Other
				
	<input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior	<input type="checkbox"/> WFL <input type="checkbox"/> L Obliquity (R elev) <input type="checkbox"/> R Obliquity (L elev)	<input type="checkbox"/> WFL <input type="checkbox"/> L Rotation (R anterior) <input type="checkbox"/> R Rotation (L anterior)	
Mobility: <input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction	<input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction	<input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction		
TRUNK	Anterior / Posterior	Lateral Flexion/Scoliosis	Trunk Rotation/Kyphoscoliosis	Tonal Influence Trunk: <input type="checkbox"/> Paralysis <input type="checkbox"/> Flaccid <input type="checkbox"/> Low Tone <input type="checkbox"/> High Tone <input type="checkbox"/> Spasticity <input type="checkbox"/> Dystonia <input type="checkbox"/> Other
				
	<input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic Kyphosis <input type="checkbox"/> ↑ Lumbar Lordosis	<input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right	<input type="checkbox"/> Neutral <input type="checkbox"/> Left-anterior <input type="checkbox"/> Right-anterior	
<input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction	<input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction	<input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction		

Name:

RIC MR#:

Insurance/recipient #

H I P S	<p style="text-align: center;">Position</p>  <p>Neutral Abduct Adduct</p> <input type="checkbox"/> Subluxed <input type="checkbox"/> Dislocated <input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction	<p style="text-align: center;">Windswept</p>  <p>Neutral Right Left</p> <input type="checkbox"/> Fixed –no mvmt available <input type="checkbox"/> Tendency away from neutral <input type="checkbox"/> Flexible to neutral <input type="checkbox"/> Self correction <input type="checkbox"/> External correction	<p>Hip R.O.M.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>WFL</th> <th>Left limits</th> <th>Right limits</th> </tr> </thead> <tbody> <tr> <td>Hip Flexion</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hip Ext</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hip Abd</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hip Add</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Describe Tone/Movements LE:</p> <input type="checkbox"/> Paralysis <input type="checkbox"/> Flaccid <input type="checkbox"/> Low Tone <input type="checkbox"/> High Tone <input type="checkbox"/> Spasticity <input type="checkbox"/> Dystonia <input type="checkbox"/> Rocks/Extends at Hip <input type="checkbox"/> Kicks into Knee extension <input type="checkbox"/> Pushes legs downward into footrests <input type="checkbox"/> Other <input type="checkbox"/> Edema LE Describe:		WFL	Left limits	Right limits	Hip Flexion				Hip Ext				Hip Abd				Hip Add																																									
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KNEES & FEET	<p>Knee R.O.M.</p> <p>Left Right</p> <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Limitations <input type="checkbox"/> Limitations	<p>Foot Positioning</p> <input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R ROM concerns: Dorsi-Flexed <input type="checkbox"/> L <input type="checkbox"/> R Plantar Flexed <input type="checkbox"/> L <input type="checkbox"/> R Inversion <input type="checkbox"/> L <input type="checkbox"/> R Eversion <input type="checkbox"/> L <input type="checkbox"/> R	<p>Describe Tone/Movement of head and Neck:</p>																																																										
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Patient Name

POSTURE/DEFORMITY/SUPPORT NEEDED

HEAD & NECK Posture/Positioning WFL Postural needs not to be treated with mobility system

UPPER EXTREMITIES Posture/Positioning WFL Postural needs not to be treated with mobility system

TRUNK Posture/Positioning WFL Postural needs not to be treated with mobility system

PELVIS Posture/Positioning WFL Postural needs not to be treated with mobility system

HIPS Posture/Positioning WFL Postural needs not to be treated with mobility system

KNEES Posture/Positioning WFL Postural needs not to be treated with mobility system

FEET & ANKLES Posture/Positioning WFL Postural needs not to be treated with mobility system

Patient Name

MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION

MOBILITY BASE	JUSTIFICATION	
Manufacturer Model Color Seat Width Seat Depth Length of need	<input type="checkbox"/> provide transport from point A to B <input type="checkbox"/> promote independent mobility <input type="checkbox"/> not a safe, functional ambulator <input type="checkbox"/> walker or cane inadequate <input type="checkbox"/> non-ambulatory	<input type="checkbox"/> non-standard width/depth necessary to accommodate anatomical measurement
<input type="checkbox"/> Lightweight Manual Wheelchair	<input type="checkbox"/> self-propulsion	
<input type="checkbox"/> High-strength Lightweight MWC	<input type="checkbox"/> self-propulsion <input type="checkbox"/> full-time daily use <input type="checkbox"/>	<input type="checkbox"/> lifting <input type="checkbox"/> requires features not available on a lightweight manual wheelchair
<input type="checkbox"/> Ultra-lightweight MWC Axle adjustability <input type="checkbox"/> Semi adjustable <input type="checkbox"/> fully adjustable	<input type="checkbox"/> improved UE access to wheels <input type="checkbox"/> efficient propulsion <input type="checkbox"/>	<input type="checkbox"/> increase chair stability <input type="checkbox"/> change angle for improved postural stability
<input type="checkbox"/> Heavy-duty Manual Wheelchair <input type="checkbox"/> Extra Heavy-duty MWC	<input type="checkbox"/> user weight _____ <input type="checkbox"/>	<input type="checkbox"/> broken frame on previous chair <input type="checkbox"/> extreme tone/excess movement
<input type="checkbox"/> Scooter/POV	<input type="checkbox"/> non-ambulatory <input type="checkbox"/> can not functionally propel manual wheelchair <input type="checkbox"/>	<input type="checkbox"/> has adequate trunk stability <input type="checkbox"/> can safely operate & is willing to
* <input type="checkbox"/> Basic Power Mobility Base	<input type="checkbox"/> non-ambulatory <input type="checkbox"/> can not functionally propel manual wheelchair <input type="checkbox"/> can not functionally and safely operate scooter	<input type="checkbox"/> can safely operate & is willing to <input type="checkbox"/> can safely transfer
<input type="checkbox"/> Power Mobility Base with <input type="checkbox"/> Programmable Electronics	<input type="checkbox"/> non-ambulatory <input type="checkbox"/> can not functionally propel manual wheelchair <input type="checkbox"/> can not functionally and safely operate scooter/POV <input type="checkbox"/> can not functionally and safely operate a basic PWC	<input type="checkbox"/> can safely operate & is willing to <input type="checkbox"/> can safely transfer <input type="checkbox"/> requires speed adjustment <input type="checkbox"/> requires torque adjustability <input type="checkbox"/> requires sensitivity adjustability <input type="checkbox"/> requires acceleration adjustability <input type="checkbox"/> requires braking adjustability
<input type="checkbox"/> Stroller Base	<input type="checkbox"/> infant/child <input type="checkbox"/> Unable to propel manual wheelchair <input type="checkbox"/>	<input type="checkbox"/> non-functional ambulator <input type="checkbox"/> non-functional UE
<input type="checkbox"/> Tilt Base or Tilt added <input type="checkbox"/> Forward <input type="checkbox"/> Rearward <input type="checkbox"/> Powered tilt on power chair <input type="checkbox"/> Powered tilt on manual chair <input type="checkbox"/> Manual tilt on manual base <input type="checkbox"/> Manual tilt on power base	<input type="checkbox"/> change position against gravitational force on head and shoulders <input type="checkbox"/> change position for pressure relief/cannot weight shift <input type="checkbox"/>	<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

Patient Name _____

MOBILITY BASE COMPONENTS	JUSTIFICATION	
Recline <input type="checkbox"/> Power recline on power base <input type="checkbox"/> Power recline on manual base <input type="checkbox"/> Manual recline on manual base <input type="checkbox"/> Manual recline on power 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/cannot weight shift <input type="checkbox"/>	<input type="checkbox"/> rest periods <input type="checkbox"/> repositioning for transfers or clothing/diaper/catheter management <input type="checkbox"/> head positioning
Elevator on Mobility Base <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter	<input type="checkbox"/> increase Indep in transfers <input type="checkbox"/> increase Indep in ADLs <input type="checkbox"/>	<input type="checkbox"/> raise height for communication at standing level
* 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"/> pad tubular	<input type="checkbox"/> provide support with elbow at 90° <input type="checkbox"/> provide support for w/c tray <input type="checkbox"/> change height/angle for ADLs <input type="checkbox"/>	<input type="checkbox"/> remove for transfers <input type="checkbox"/> allow to come closer to table <input type="checkbox"/> remove for access to tables
Footrests/Leg rests <input type="checkbox"/> 60° <input type="checkbox"/> 70° <input type="checkbox"/> 80° <input type="checkbox"/> 90° <input type="checkbox"/> heavy duty <input type="checkbox"/> elevating <input type="checkbox"/> articulating elevating <input type="checkbox"/> power elevating leg rests <input type="checkbox"/> power articulating foot platform	<input type="checkbox"/> provide LE support <input type="checkbox"/> accommodate hamstring tightness <input type="checkbox"/> accommodate knee ROM <input type="checkbox"/> elevate legs during recline <input type="checkbox"/> provide change in position for legs <input type="checkbox"/> maintain feet on footplate <input type="checkbox"/>	<input type="checkbox"/> Power elevating turning radius limits access to critical areas of home <input type="checkbox"/> decrease edema <input type="checkbox"/> physically unable to operate manual elevating legrests
Foot Support <input type="checkbox"/> Flip up <input type="checkbox"/> foot platform <input type="checkbox"/> Adjustable angle	<input type="checkbox"/> provide foot support <input type="checkbox"/> accommodate ankle ROM <input type="checkbox"/> allow foot to go under w/c base	<input type="checkbox"/> transfers <input type="checkbox"/> accommodate AFO angle
Drive/propulsion wheel size: _____ Wheel style <input type="checkbox"/> mag <input type="checkbox"/> spokes	<input type="checkbox"/> increase access to wheel <input type="checkbox"/> allow seating system to fit on base	<input type="checkbox"/> increase propulsion ability <input type="checkbox"/>
Quick release wheels	<input type="checkbox"/> allow wheels to be removed to decrease width of w/c for storage	<input type="checkbox"/> decrease weight for lifting <input type="checkbox"/>
Wheel rims/hand rims <input type="checkbox"/> Metal <input type="checkbox"/> plastic coated <input type="checkbox"/> Projections <input type="checkbox"/> oblique <input type="checkbox"/> vertical	<input type="checkbox"/> increase self-propulsion with hand weakness/decreased grasp	<input type="checkbox"/>
Drive/propulsion tires <input type="checkbox"/> pneumatic <input type="checkbox"/> flat free	<input type="checkbox"/> prevent frequent flats <input type="checkbox"/> increase shock absorbency	<input type="checkbox"/>
Caster <input type="checkbox"/> pneumatic <input type="checkbox"/> flat free	<input type="checkbox"/> prevent frequent flats	<input type="checkbox"/>
Specific seat height Floor to seat height _____	<input type="checkbox"/> foot propulsion <input type="checkbox"/> transfers	<input type="checkbox"/> accommodation of leg length <input type="checkbox"/>
Shock absorbers	<input type="checkbox"/> decrease vibration	<input type="checkbox"/> decrease pain
Spoke protector	<input type="checkbox"/> protect hand/fingers from spokes	<input type="checkbox"/>
Side guards	<input type="checkbox"/> prevent skin tears/abrasions	<input type="checkbox"/>
One armed drive attachment <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> enable propulsion of manual wheelchair with one arm	<input type="checkbox"/>
Anti-tippers	<input type="checkbox"/> prevent rearward displacement	<input type="checkbox"/>
Amputee adapter	<input type="checkbox"/> increase rearward stability	<input type="checkbox"/>

Patient Name

MOBILITY BASE COMPONENTS	JUSTIFICATION	
Mount for switches or joystick	<input type="checkbox"/> attaches switches to w/c <input type="checkbox"/> swing-away for safe transfers	<input type="checkbox"/> midline for optimal placement
Attendant controlled joystick and 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
* Battery	<input type="checkbox"/> power motors on wheelchair	<input type="checkbox"/>
* Charger	<input type="checkbox"/> charge battery for wheelchair	<input type="checkbox"/>
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
Other		
Other		

SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

COMPONENT	Mfg/model size	JUSTIFICATION	
<input type="checkbox"/> Seat cushion		<input type="checkbox"/> impaired sensation <input type="checkbox"/> decubitus ulcers present <input type="checkbox"/> history of decubitus ulcers <input type="checkbox"/> increase pressure distribution <input type="checkbox"/>	<input type="checkbox"/> stabilize pelvis <input type="checkbox"/> prevent pelvic extension <input type="checkbox"/> accommodate obliquity/rotation <input type="checkbox"/> accommodate multiple deformity <input type="checkbox"/> neutralize LE <input type="checkbox"/>
<input type="checkbox"/> Seat cushion - Custom Molded		<input type="checkbox"/> commercially available cushion cannot accommodate deformity <input type="checkbox"/>	
<input type="checkbox"/> Seat Wedge		<input type="checkbox"/> accommodate ROM <input type="checkbox"/> aggressive seat shape to decrease slipping down in the seat	<input type="checkbox"/>
<input type="checkbox"/> Cover replacement		<input type="checkbox"/> protect back or seat cushion	<input type="checkbox"/>
<input type="checkbox"/> Mounting hardware <input type="checkbox"/> lateral supports <input type="checkbox"/> headrest <input type="checkbox"/> medial thigh support <input type="checkbox"/> back <input type="checkbox"/> seat	<input type="checkbox"/> fixed <input type="checkbox"/> swing away	<input type="checkbox"/> attach seat platform/cushion <input type="checkbox"/> attach back platform/cushion <input type="checkbox"/> mount postural support(s) <input type="checkbox"/>	<input type="checkbox"/> swing away for safe transfers <input type="checkbox"/> flip-down/away for safe transfers <input type="checkbox"/> multi-axis for accurate positioning & removal for safe transfers
<input type="checkbox"/> Seat board <input type="checkbox"/> Seat platform <input type="checkbox"/> Back board		<input type="checkbox"/> support cushion to prevent hammocking of upholstery <input type="checkbox"/>	<input type="checkbox"/> attach cushion/back to base <input type="checkbox"/> accommodate seat to floor height
<input type="checkbox"/> Back cushion		<input type="checkbox"/> provide posterior trunk support <input type="checkbox"/> provide posterior/lateral trunk support <input type="checkbox"/> accommodate deformity <input type="checkbox"/> accommodate or decrease tone <input type="checkbox"/> facilitate tone	<input type="checkbox"/> provide lumbar/sacral support <input type="checkbox"/> support trunk in midline <input type="checkbox"/> pressure relief over spinous processes <input type="checkbox"/>
<input type="checkbox"/> Back cushion - Custom Molded		<input type="checkbox"/> commercially available back cannot accommodate deformity <input type="checkbox"/>	

Patient Name

COMPONENT	Mfg/model size	JUSTIFICATION	
<input type="checkbox"/> Lateral pelvic/ thigh support	<input type="checkbox"/> R <input type="checkbox"/> L	<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"/>
<input type="checkbox"/> Medial thigh support		<input type="checkbox"/> decrease adduction <input type="checkbox"/> accommodate ROM	<input type="checkbox"/> remove for transfers <input type="checkbox"/> alignment
<input type="checkbox"/> Foot support <input type="checkbox"/> Foot box <input type="checkbox"/> Shoe holder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> position foot <input type="checkbox"/> accommodate deformity <input type="checkbox"/>	<input type="checkbox"/> stability <input type="checkbox"/> decrease tone <input type="checkbox"/> control position
<input type="checkbox"/> Ankle strap/ heel loops		<input type="checkbox"/> support foot on foot support <input type="checkbox"/> decrease extraneous movement <input type="checkbox"/>	<input type="checkbox"/> provide input to heel <input type="checkbox"/> protect foot
<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"/> safety <input type="checkbox"/> control of tone <input type="checkbox"/>
<input type="checkbox"/> Anterior chest strap, vest, or shoulder retractors		<input type="checkbox"/> decrease forward movement of shoulder <input type="checkbox"/> accommodation of TLSO <input type="checkbox"/> decrease forward movement of trunk <input type="checkbox"/>	<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"/> 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"/> 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
<input type="checkbox"/> Upper extremity support <input type="checkbox"/> Arm Trough <input type="checkbox"/> ___ Hand Support <input type="checkbox"/> ½ tray <input type="checkbox"/> Full tray <input type="checkbox"/> Swivel mount	<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"/>	<input type="checkbox"/> decrease gravitational pull on shoulders <input type="checkbox"/> provide midline positioning <input type="checkbox"/> provide support for UE function <input type="checkbox"/> provide hand support in natural position
<input type="checkbox"/> Pelvic positioning strap		<input type="checkbox"/> stabilize tone <input type="checkbox"/> decrease falling out of chair ** will not decrease potential for sliding due to pelvic tilting <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"/> Essential needs 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

Patient Name

COMPONENT	Mfg/model size	JUSTIFICATION
Other		

Patient/Client/Caregiver Signature		Date
Therapist Name Printed		
Therapist's Signature		Date
Supplier's Name Printed		
Supplier's Signature		Date

I agree with the above findings and recommendations of the therapist and supplier

Physician's Name Printed		
Physician's 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

Functional Mobility Transfers, Gait, Endurance, and Safety

PARAMETER	SCORE	INTERPRETATION	BORG RATE OF PERCEIVED EXERTION
TRANSFERS 30 Second Sit to Stand Test	Sit to Stand Score Reps	Score of 8 Repetitions or less predicts risk for loss of functional mobility requiring lower body strength (Rickli and Jones, 2001).	
FALL RISK/ TRANSFERS/ GAIT Timed Up and Go Test	Timed Up and Go Score Seconds	Over 13.5 seconds indicates heightened fall risk in community dwelling older adults. (Dite W & Temple V, 2002). 30 seconds or more was found to be the cutoff for ADL Dependence. (Podsiadlo D & Richardson S, 1991)	
GAIT Normal Gait Speed	Normal Gait Speed Score m/sec	Gait Speed of .6 m/sec or slower fairly predicts increased risk of falls in community dwelling older adults (Van Swearingon JM 1998). Gait speed less than .6 m/sec is predictive of decline in physical function and new difficulty in personal care (over the following year). (Studenski, Perera, et al 2003) Gait velocity .6m/sec or less was a predictor of hospitalization, requirement of a caregiver, and new falls (Montero-Odasso, Schapira, et al 2005).	
GAIT Fast Gait Speed	Fast Gait Speed Score m/sec		
ENDURANCE 2 Minute Step Test	2 Minute Step Test Score Repetitions	Score of <65 steps indicates risk for loss endurance related functional mobility (Rickli and Jones, 2001)	
ENDURANCE 6 Minute Walk Test	6 Minute Walk Test Score	An Independent community ambulator can walk for distances of 1300 feet (400 meters) at a speed of at least 50% of normal. Adapted from: Perry J, Garrett M, Gronely JK, Mulroy SJ. Stroke 1995	

RANGE OF MOTION, STRENGTH, AND FUNCTION ASSESSMENT

UPPER EXTREMITY FUNCTION

<u>BACK SCRATCH TEST</u> Upper Extremity Functional Flexibility	LEFT HAND OVER RIGHT: RIGHT HAND OVER LEFT:	A Back Scratch score of (-4.5) or below for women, or (-8) or below for men --indicates mobility problems with tasks and physical activities requiring upper-body flexibility (Senior Fitness Test, Rickli and Jones, 2001).
<u>ARM CURL TEST</u> Upper Extremity Functional Strength	RIGHT ARM CURL SCORE: LEFT ARM CURL SCORE:	An arm curl score of eleven (11) or below for men or women—indicates upper body strength is too low to perform many normal everyday activities without assistance (Senior Fitness Test, Rickli and Jones, 2001).
NEUROLOGICAL Upper Extremity Tone (Tone is an abnormal muscular state usually the result of a neurological issue).	MODIFIED ASHWORTH SCALE (for increased muscle tone) no abnormal tone present	

LOWER EXTREMITY

<u>SIT REACH TEST</u> Lower Extremity Functional Flexibility	SIT REACH TEST: INCHES RIGHT INCHES LEFT	A chair sit-and-reach score of minus two (-2) or below for women, or a minus four (-4) or below for men --at risk for developing mobility problems and limitations in physical activities requiring lower-body flexibility (Senior Fitness Test, Rickli and Jones, 2001).
<u>30 SECOND SIT TO STAND</u> Lower Extremity Functional Strength	30 SECOND CHAIR STAND TEST SCORE:	Less than 8 reps—at risk for developing mobility problems and limitations in physical activity requiring lower body strength (Senior Fitness Test, Rickli and Jones, 2001.)
NEUROLOGICAL Lower Extremity Tone (Tone is an abnormal muscular state usually the result of a neurological issue).	MODIFIED ASHWORTH SCALE (for increased muscle tone) no abnormal tone present	
LE NOTES		

THE BARTHEL INDEX

Patient Name: _____

Rater Name: _____

Date: _____

Activity _____ **Score** _____

FEEDING

0 = unable

5 = needs help cutting, spreading butter, etc., or requires modified diet

10 = independent

BATHING

0 = dependent

5 = independent (or in shower)

GROOMING

0 = needs to help with personal care

5 = independent face/hair/teeth/shaving (implements provided)

DRESSING

0 = dependent

5 = needs help but can do about half unaided

10 = independent (including buttons, zips, laces, etc.)

BOWELS

0 = incontinent (or needs to be given enemas)

5 = occasional accident

10 = continent

BLADDER

0 = incontinent, or catheterized and unable to manage alone

5 = occasional accident

10 = continent

TOILET USE

0 = dependent

5 = needs some help, but can do something alone

10 = independent (on and off, dressing, wiping)

TRANSFERS (BED TO CHAIR AND BACK)

0 = unable, no sitting balance

5 = major help (one or two people, physical), can sit

10 = minor help (verbal or physical)

15 = independent

MOBILITY (ON LEVEL SURFACES)

0 = immobile or < 50 yards

5 = wheelchair independent, including corners, > 50 yards

10 = walks with help of one person (verbal or physical) > 50 yards

15 = independent (but may use any aid; for example, stick) > 50 yards

STAIRS

0 = unable

5 = needs help (verbal, physical, carrying aid)

10 = independent

TOTAL (0-100): _____

The Barthel ADL Index: Guidelines

1. The index should be used as a record of what a patient does, not as a record of what a patient could do.
2. The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.
3. The need for supervision renders the patient not independent.
4. A patient's performance should be established using the best available evidence. Asking the patient, friends/relatives and nurses are the usual sources, but direct observation and common sense are also important. However direct testing is not needed.
5. Usually the patient's performance over the preceding 24-48 hours is important, but occasionally longer periods will be relevant.
6. Middle categories imply that the patient supplies over 50 per cent of the effort.
7. Use of aids to be independent is allowed.

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Maryland State Medical Journal 1965;14:56-61. Used with permission.

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Braden Risk Assessment Scale

NOTE: Bed and chairbound individuals or those with impaired ability to reposition should be assessed upon admission for their risk of developing pressure ulcers. Patients with established pressure ulcers should be reassessed periodically.

Patient Name: _____ Room Number: _____ Date: _____

Sensory Perception	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment	<i>Indicate Appropriate Numbers Below</i>
Ability to respond meaningfully to pressure-related discomfort	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.	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 1/2 of body.	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.	Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	
Moisture	1. Constantly Moist	2. Very Moist	3. Occasionally Moist	4. Rarely Moist	
Degree to which skin is exposed to moisture	Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	Skin is often, but not always, moist. Linen must be changed at least once a shift.	Skin is occasionally moist, requiring an extra linen change approximately once a day.	Skin is usually dry. Linen only requires changing at routine intervals.	
Activity	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently	
Degree of physical activity	Confined to bed.	Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	
Mobility	1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitations	
Ability to change and control body position	Does not make even slight changes in body or extremity position without assistance.	Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	Makes frequent though slight changes in body or extremity position independently.	Makes major and frequent changes in position without assistance.	
Nutrition	1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent	
Usual food intake pattern	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 NPO and/or maintained on clear liquids or I.V.'s for more than 5 days.	Rarely eats a complete meal and generally eats only about 1/2 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.	Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	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.	
Friction and Shear	1. Problem	2. Potential Problem	3. No Apparent 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 lead to almost constant friction.	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.	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.		

NOTE: Patients with a total score of 16 or less are considered to be at risk of developing pressure ulcers. (15 or 16 = low risk; 13 or 14 = moderate risk; 12 or less = high risk)

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Total Score:

Wheelchair Propulsion Test (WPT)[®] Version 1.0 Form

Subject # : _____ . Date: _____ . Time: _____ Test # _____

Recorded Data*	
1. Able to successfully complete the 10m distance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Direction of travel	Forward <input type="checkbox"/> Backward <input type="checkbox"/>
3. Limbs contributing to propulsion, steering or braking (tick all that apply)	Left: Hand <input type="checkbox"/> Leg <input type="checkbox"/> Right: Hand <input type="checkbox"/> Leg <input type="checkbox"/>
4. Limb monitored for timing propulsion cycles (tick one limb)	Left: Hand <input type="checkbox"/> Leg <input type="checkbox"/> Right: Hand <input type="checkbox"/> Leg <input type="checkbox"/>
5. Time (to nearest second)	_____ s
6. Total number of propulsive cycles (to nearest full cycle)	_____ cycles
7. If using one or more hands for propulsion in the forward direction, during the <i>contact phases</i> , did the subject generally begin the contact between the hands and the hand-rims behind the top dead center of the rear wheel?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>
8. If using one or more hands for propulsion in the forward direction, during the <i>recovery phases</i> , did the subject generally use a path of the hands that was predominantly beneath the hand-rims?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>
9. If using one or more <i>feet for propulsion</i> and going forward, did the subject make initial foot contact with the knee flexed less than 90° from full extension and finish with the knee flexed more than 90° (or the opposite if going backward)?	Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable <input type="checkbox"/>
10. Comments: (e.g., position on seat, trunk and arm posture, hand grip, foot contact, consistency, need for training, footwear, equipment worn, wheelchair issues)	
Derived Wheelchair-Propulsion Data*	
1. Speed: 10m / _____ # seconds =	_____ m/s
2. Push frequency (cadence): _____ # cycles / _____ # seconds =	_____ cycles/s
3. Effectiveness: 10m / _____ # cycles =	_____ m/cycle

*Directions on next page.

Tester signature: _____ Tester name (print): _____

Wheelchair Propulsion Test (WPT)[®] Version 1.0 Directions

- A. Equipment and set-up:
- Means of recording the time (to the nearest second).
 - A 10 m path at least 1.2m wide on a smooth level surface is needed, with at least 2 m before the starting line and at least 2m beyond the finish line. The starting lines and path width should be clearly indicated. Note that longer distances (e.g. 100m) can be used with the same methodology, depending upon the purpose of the test.
- B. Starting position: Wheelchair user seated in wheelchair at rest, with the wheel locks off, behind the starting line, facing forward or backwards, at the wheelchair user's preference. The casters should be oriented as they will be for moving in the selected direction. The tester positions himself/herself where it is best possible to view the limb being used to record the number of cycles and to view the leading wheel as it crosses the finish line.
- C. Safety: The tester is attentive to and in a position to spot for rear tips or forward falls from the wheelchair, especially during the starting and stopping stages of the test.
- D. Instructions:
- The test subject may do a practice attempt to familiarize him/her with the instructions and to provide the tester with an indication of what limb should be used for counting the cycles and propulsion method.
 - Orally or in writing, the tester instructs the test subject as follows: "When you are ready, please propel your wheelchair to the finish area using your usual method and speed". The tester should indicate the finish area beyond the finish line. If it becomes clear that the wheelchair user did not understand the instructions (e.g. stopping before the finish line rather than beyond it), the test may be repeated.
- E. What the tester records: The tester uses the form on the previous page to record the following data:
1. Success at completing the 10m task (yes/no).
 2. Direction of travel (forward/backward).
 3. Limbs contributing to propulsion, steering or braking (left arm, right arm, left leg and/or right leg). Tick all that apply.
 4. Limb monitored for timing propulsion cycles (left arm, right arm, left leg or right leg). Tick one. For people with hemiplegia using an arm and a leg, generally use the leg for counting the cycles.
 5. Time (to the nearest second) from when the leading wheels cross the starting line until they cross the finish line. The tester should not be obvious about timing the test, to avoid encouraging speed.
 6. Total number of propulsive cycles in 10m (to nearest full cycle). A cycle is defined as beginning when the limb being monitored makes the initial contact with the hand-rim (if an arm) or the ground (if a leg). The end of the cycle is when this event occurs the next time.
 7. If using one or more hands for propulsion in the forward direction, during the contact phase, did the subject generally begin the contact between the hands and the hand-rims behind the top dead center of the rear wheel? (yes/no/not applicable).
 8. If using one or more hands for propulsion in the forward direction, during the recovery phases, did the subject generally use a path of the hands that was predominantly beneath the hand-rims? (yes/no/not applicable).
 9. If using one or more feet for propulsion, did the subject make initial foot contact with the knee flexed less than 90° from full extension and finish with the knee flexed more than 90° (or the opposite if going backward)? (yes/no/not applicable).
 10. Comments: The tester notes anything relevant (e.g. position on seat, trunk and arm posture, hand grip, foot contact, consistency, need for training, footwear, equipment worn, wheelchair issues).
- F. What the tester calculates: The tester calculates the following derived parameters:
1. Speed: $10\text{m}/\# \text{ of seconds} = \# \text{ m/s}$
 2. Push frequency (or cadence): $\# \text{ of cycles} / \# \text{ of seconds} = \# \text{ cycles/s}$
 3. Effectiveness: $10 \text{ m} / \# \text{ of cycles} = \# \text{ m/cycles}$

Note:

- No permission is needed to use the WPT, nor are there any charges.