Wheeled Mobility and Seating Evaluation

PATIENT INFORMATION

Name _____ DOB _____ Sex ___ Date _____ Time _____

Address _____ City _____ State _____ ZIP _____

Phone # _____ Spouse/Parent/Caregiver Name _____ Phone # _____

Physician _____ MD Phone # _____ MD NPI # _____

Therapist _____ Therapist Phone # _____ Seating CRT Experience _____ yrs.

Medical Record # _____ 1° Insurance/Payor _____ Policy # _____

D/C Date _____ 2° Insurance/Payor _____ Policy # _____

The following supplier ATP was present and participated in this evaluation and recommendation Name _____

Supplier Company _____ Phone # _____

Reason for Referral ☐ Current w/c no longer meets needs ☐ Current w/c beyond repair ☐ Ambulation not independent, safe, or timely ☐ Non-ambulatory

☐ Other _____

Patient Goals _____

Caregiver Goals _____

Specific Mobility Limitations that May Affect Care _____

Overall initial FMA Score (If applicable) _____ ☐ See FMA in Medical Record ☐ Other outcome measure used and initial score _____

MEDICAL HISTORY

Diagnosis

ICD10 Code _____ 1° Dx _____ Onset _____ ICD10 Code _____ Diagnosis _____

ICD10 Code _____ Diagnosis _____ ICD10 Code _____ Diagnosis _____

☐ Progressive Disease Relevant Past and/or Future Surgeries ☐ Bone ☐ Skin ☐ Muscle ☐ Joint ☐ Other _____

Height _____ in. Weight _____ lbs. Explain recent changes or trends in weight _____

Pertinent Medical History

Autonomic System

☐ Intact ☐ Impaired ☐ Hx of Autonomic Dysreflexia ☐ Hx of Thermoregulatory Dysfunction ☐ Other _____

Functional Limitations _____

Cardiac System

Resting HR/Pulse _____ bpm Resting BP _____ / _____ bpm Comments _____

☐ Intact ☐ Impaired ☐ Pacemaker ☐ Cardiac Precautions ☐ Hx of MI ☐ Hx of A-fib ☐ Tachycardia / Bradycardia ☐ Orthostatic Hypotension ☐ Syncope

☐ Other _____

Functional Limitations _____

Pulmonary System

Resting Resp. Rate _____ bpm Resting O_2 Sat. _____ % Comments _____

☐ Intact ☐ Impaired ☐ SOB ☐ Hx of COPD ☐ Hx of PE ☐ O_2 PRN _____ L/Min. ☐ O_2 Dep. _____ L/Min. ☐ Ventilator Dep

☐ Other _____

Functional Limitations _____

Medications that may affect mobility / positioning _____

☐ See medication list in Medical Record _____

Prosthetics, Orthotics and/or Splints Used _____

Patient Name: _____

CURRENT MOBILITY ASSISTIVE EQUIPMENT (MAE) / SEATING

Current Mobility Device ☐ None ☐ Cane ☐ Walker ☐ Stroller ☐ Manual W/C ☐ MWC w/ tilt ☐ MWC w/ recline

☐ Scooter ☐ Power W/C ☐ PWC w/ tilt ☐ PWC w/ recline ☐ PWC w/ tilt & recline ☐ PWC w/ Ant tilt ☐ PWC w/ seat elevator ☐ PWC w/ stand

Manufacturer _____ Model _____ Type of control _____

Serial # _____ Color _____ Age _____ Additional Components _____

Condition of Current Mobility Device ☐ Good ☐ Fair ☐ Poor ☐ Disrepair ☐ Not safe / operational ☐ Irreparably damaged ☐ Other _____

Problems with Current Mobility Device _____

Seat Height _____ in. Seat Width _____ in. Seat Depth _____ in. Changes needed _____

Current Seating System _____ Age of Seating System _____ mo.

Component	Manufacturer	Condition / Problems
Seat Cushion		
Pelvic Support		
Lateral Hip / Thigh / Knee Support		
Medial Thigh Support		
Foot Support / Straps / Heel Loop		
Back Cushion		
Lateral Trunk Supports		
Chest / Shoulder Support		
Head Support		
UE Support		
Mounting Hardware		
Other		

When Relevant Overall W/C Length _____ in. Overall W/C Width _____ in. Overall W/C Height _____ in.

Is the current mobility device meeting the patient's physical, functional, environmental, and medical needs? ☐ Yes ☐ No

Comments

This section was completed by (check all that apply) ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document

HOME ENVIRONMENT

Setting ☐ Rural ☐ Urban ☐ Suburban ☐ Paved Roads ☐ Sidewalks ☐ Rough Terrain ☐ Hills / Steep Grade (>1:12) ☐ Other

Type ☐ House ☐ Condo/Town Home ☐ Apartment ☐ Assisted Living ☐ LTCF ☐ SNF ☐ Oher _____ ☐ Own ☐ Rent

☐ Lives Alone / No Caregivers ☐ Lives Alone / Caregiver Asst ☐ Lives with Caregiver(s) Hours Home Alone _____ hrs.

Comments _____

Ability to Safely Reach (in sitting) ☐ Dresser Drawers ☐ Clothes Rod ☐ Shelves ☐ Medicine Cabinet ☐ BR Faucet/Shower ☐ Other _____

☐ Refrigerator / Freezer ☐ Oven / Stove ☐ Microwave ☐ Kitchen Sink ☐ Cupboards / Drawers / Shelves ☐ Other _____

☐ Light Switches ☐ Thermostat ☐ Phone ☐ Fire Alarm ☐ Door Eye Hole / Viewer ☐ Elevator Buttons ☐ Other _____

☐ Uses / Requires Power Seat Elevation to Perform Reaching Activities ☐ Uses / Requires Power Standing System to Perform Reaching Activities

Home is Wheelchair Accessible ☐ Yes ☐ No Storage of Wheelchair ☐ In home ☐ Other _____

Stairs ☐ Yes ☐ No Ramp ☐ Yes ☐ No Degree Incline _____ ° Thresholds ☐ Yes ☐ No Height _____ in.

Surfaces ☐ Carpet ☐ Tile ☐ Wood ☐ Stone / Brick ☐ Other _____

Non-accessible areas in home _____ Modifications Planned ☐ Yes ☐ No

Comments

This section was completed by (check all that apply) ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document

Patient Name: _____

COMMUNITY ENVIRONMENT

Employment / Volunteer ☐ N/A ☐ Specific requirements pertaining to seating / mobility _____

School ☐ N/A ☐ Specific requirements pertaining to seating / mobility _____

Other Community Mobility ☐ N/A ☐ Medical Appointments ☐ Religious ☐ Civic Duties ☐ IADLs ☐ Other _____

☐ Specific requirements pertaining to seating / mobility _____

_____

This section was completed by (check all that apply) ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document

TRANSPORTATION

☐ Car ☐ Van ☐ SUV / Truck ☐ School Bus ☐ Van Service ☐ Public Transportation ☐ Train ☐ Airplane

☐ Other _____

Vehicle Adaptations

☐ None ☐ Ramp ☐ Lift ☐ Hand controls ☐ Other _____

☐ Tie Downs Type _____ ☐ Lock-down System Type _____

Method of Riding in Automobile

☐ Rides in w/c ☐ Rides in vehicle seat / car seat ☐ Self-drives from w/c ☐ Self-drives in driver's seat ☐ Other _____

Storage

Where is w/c stored during transport? ☐ N/A ☐ Front Seat ☐ Back Seat ☐ Trunk/Bed / Cargo area ☐ Vehicle Lift ☐ Other _____

Size of area needed for transport W _____ ft. L _____ ft. D _____ ft. If necessary, client/caregiver can load/unload equipment into vehicle ☐ Y ☐ N

Vehicle Dimensions

Door Height _____ ft. _____ in. Door Width _____ ft. _____ in. Inside Height _____ ft. _____ in.

Ramp / Lift Size Width _____ in. Length _____ in. Depth _____ in. Weight Capacity _____ lbs. Other _____

This section was completed by (check all that apply) ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document

CURRENT ADL STATUS

Getting to the location where the ADL is performed with present MAE

	Independent w/o MAE	Independent w/ current MAE	Assist w/ current MAE	Unable / Dep. w/ current MAE	N/A	Comments / Equipment
Dressing	☐	☐	☐	☐	☐	_____
Eating	☐	☐	☐	☐	☐	_____
Grooming/Hygiene	☐	☐	☐	☐	☐	_____
Toileting	☐	☐	☐	☐	☐	_____
Bathing	☐	☐	☐	☐	☐	_____
IADLS	☐	☐	☐	☐	☐	_____

Bowel Management

☐ Continent ☐ Incontinent ☐ Accidents ☐ Protective Undergarments ☐ Colostomy ☐ Bowel Program

Comments _____

Bladder Management

☐ Continent ☐ Incontinent ☐ Accidents ☐ Protective Undergarments ☐ Urinal / Bed Pan / Commode ☐ Bladder Program

☐ Intermittent Catheterization ☐ Indwelling Catheter ☐ External / Condom Catheter ☐ Supra-pubic Catheter

Comments _____

Describe what has Changed to Require New and/or Different Mobility Assistive Equipment

Patient Name: _____

PHYSICAL / FUNCTIONAL EVALUATION

VERBAL COMMUNICATION

1° Language _____ 2° Language _____

Communication provided by ☐ Patient ☐ Family / Caregiver ☐ Translator ☐ AAC ☐ Other _____

☐ WFL Receptive ☐ WFL Expressive ☐ Understandable ☐ Difficult to Understand ☐ Non-communicative

☐ Non-Verbal Communication Method _____ ☐ AAC Device Manufacturer Make/Model _____

☐ AAC Mount Needed Type _____

PROCESSING SKILLS for WHEELED MOBILITY

Visual Processing	☐ Intact	☐ Impaired	☐ Compensated	Comments _____
Motor Planning & Execution	☐ Intact	☐ Impaired	☐ Compensated	Comments _____
Safety Awareness of Self/Others	☐ Intact	☐ Impaired	☐ Compensated	Comments _____
Visual Processing	☐ Intact	☐ Impaired	☐ Compensated	Comments _____
Behavioral Status	☐ Intact	☐ Impaired	☐ Compensated	Comments _____

Additional Comments Regarding Processing Skills and Ability to Safely Use Wheelchair

PAIN, SENSATION and SKIN INTEGRITY

Complaint of Pain

Severity (No Pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Worst)

Location(s) _____

How does pain affect mobility, sitting, and/or ADLs? _____

Sensation

☐ Intact ☐ Impaired ☐ Absent ☐ Hypo sensate ☐ Hyper sensate Location(s) _____

Comments _____

Skin Integrity

Current Skin Integrity ☐ Intact ☐ At Risk ☐ Red Area ☐ Open Area ☐ Scar Tissue

Stage _____ Location _____ Size _____

Stage _____ Location _____ Size _____

Hx of Pressure Injury ☐ Yes ☐ No Location(s) _____ When _____

Limited Sitting Tolerance ☐ Yes ☐ No Hours per Day _____

Hx of Skin Flap Surgery ☐ Yes ☐ No Location(s) _____ When _____

Comments _____

Risk Factors for Skin

Braden Score (if administered) _____ Note: Braden Scale is used for individuals who are bed bound – not for seated persons

☐ Boney Prominences ☐ Immobility ☐ Prolonged Sitting ☐ Impaired Nutrition and/or Hydration ☐ Aging Skin ☐ Compromised Circulation

☐ Incontinence ☐ Moisture Build Up (Perspiration, Skin Folds) ☐ Other _____

Pressure Relief / Distribution / Tissue Perfusion

Able to perform independent and effective pressure relief/reperfusion at seated surface ☐ Yes ☐ No

Method ☐ Stand up (indep, w/o risk of falling) ☐ Lean side-to-side (w/o risk of falling) ☐ W/C push-up (4+ times/hour for 15+ sec.)

Pressure relief method(s) performed consistently throughout the day ☐ Yes ☐ No If no, why not? _____

Uses / requires seat functions to perform pressure relief ☐ Yes ☐ No ☐ Tilt in Space ☐ Recline ☐ Tilt & Recline ☐ Power Standing

Pressure Map Results _____ ☐ N/A ☐ On File

Comments

Patient Name: _____

STRENGTH / RANGE OF MOTION

Gross Overall Strength

Upper Extremity			Lower Extremity		
☐ Normal (5/5)		☐ -	☐ Normal (5/5)		☐ -
☐ Good (4/5)	☐ +	☐ -	☐ Good (4/5)	☐ +	☐ -
☐ Fair (3/5)	☐ +	☐ -	☐ Fair (3/5)	☐ +	☐ -
☐ Poor (2/5)	☐ +	☐ -	☐ Poor (2/5)	☐ +	☐ -
☐ Trace (1/5)	☐ +	☐ -	☐ Trace (1/5)	☐ +	☐ -
☐ No Movement	☐ +	☐ -	☐ No Movement	☐ +	☐ -

☐ Manual Muscle Test on file/limitations noted on pages 6 - 8

Gross Range of Motion

Shoulder _____
Elbow _____
Wrist _____
Hand _____
Hip _____
Knee _____
Ankle _____

☐ Goniometric Measurements on file/limitations noted on pages 6 - 8

Comments

BALANCE

Static Sitting	Dynamic Sitting	Static Standing	Dynamic Standing	
☐ Normal	☐ Normal	☐ Normal	☐ Normal	☐ Sitting balance does not permit functional weight shift
☐ Good	☐ Good	☐ Good	☐ Good	☐ Sitting requires external support
☐ Fair	☐ Fair	☐ Fair	☐ Fair	
☐ Poor	☐ Poor	☐ Poor	☐ Poor	☐ Standing balance does not permit functional weight shift
☐ Unable / Dependent	☐ Unable / Dependent	☐ Unable / Dependent	☐ Unable / Dependent	☐ Standing requires external support
☐ Fluctuates	☐ Fluctuates	☐ Fluctuates	☐ Fluctuates	

Comments

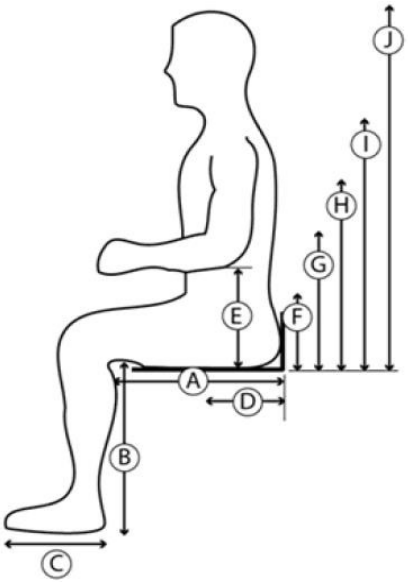
NEURO-MOTOR

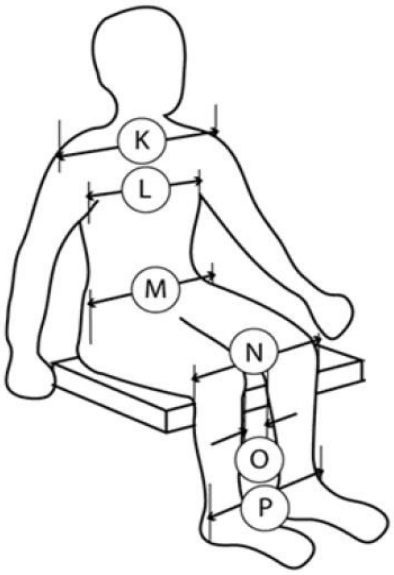
☐ WNL	☐ Dystonia	**Modified Ashworth Score (0, 1, 1+, 2, 3, 4)**
☐ Spasticity/Hypertonicity	☐ Primitive Reflexes	☐ Muscle(s) Tested ☐ On File ☐ Noted on pages 6 - 8 Score
☐ Flaccidity/Hypotonicity	☐ Intention / Resting Tremors	_____ _____
☐ Fluctuating Tone	☐ Muscle Spasms / Clonus	_____ _____
☐ Ataxia	☐ Paralysis	_____ _____
☐ Athetoid Movements	☐ _____	_____ _____

Comments

Patient Name: _____

MEASUREMENTS in SITTING





Comments

	Left	Right			Measurement
A Buttock / thigh depth			J	Top of Head	
B Lower leg length			K	Shoulder width	
C Foot length			L	Chest width	
D Ischial depth			M	Hip width	
E Seat to elbow height			N	External knee width	
F PSIS height			O	Internal knee width	
G Inferior scapular height			P	External ankle/foot (widest point)	
H Axilla height			Other		
I Shoulder height (top)					
+ Overall width (asymmetrical width for windswept legs, scoliotic posture or other asymmetry)			+	windswept legs, scoliotic posture or other asymmetry)	

This section was completed by (check all that apply) ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document

Hamstring Flexibility with Regard to Seating Angles

Accommodate	☐ Left	☐ Right	☐ Both	☐ Left	☐ Right	☐ Both	Comments
Pelvis to thigh angle	☐ Greater than 90°			☐ Less than 90°			
Thigh to trunk angle	☐ Greater than 90°			☐ Less than 90°			
Thigh to calf angle	☐ Greater than 90°			☐ Less than 90°			

Seating Notes

Patient Name: _____

POSTURE IN SITTING

PELVIS

Anterior / Posterior

☐ Neutral ☐ Posterior ☐ Anterior

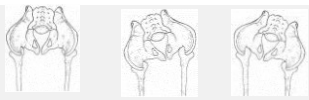
☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

Obliquity (from behind)

☐ WFL ☐ L Low (Obliquity) ☐ R Low (Obliquity)

☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

Rotation – Pelvis



☐ WFL ☐ Right Anterior ☐ Left Anterior

☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

Tonal Influence – Pelvis

☐ WNL
☐ Paralysis
☐ Flaccid
☐ Low Tone
☐ High Tone
☐ Spasticity
☐ Dystonia
☐ Pelvic Thrust
☐ Other _____

Comments _____

TRUNK

Anterior / Posterior

☐ WFL ☐ ↑ Thoracic Kyphosis ☐ ↓ Thoracic Kyphosis
☐ ↓ Lumbar Lordosis ☐ ↑ Lumbar Lordosis

☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

Left / Right

☐ WFL ☐ Convex Left ☐ Convex Right
☐ C-curve ☐ S-curve
☐ Multiple Apex Curves

☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

Rotation – Shoulders/Upper Trunk

☐ WFL ☐ Left Anterior ☐ Right Anterior

☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

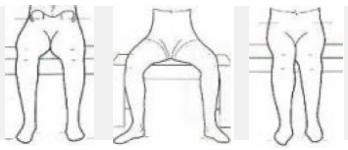
Tonal Influence – Trunk

☐ WNL
☐ Paralysis
☐ Flaccid
☐ Low Tone
☐ High Tone
☐ Spasticity
☐ Dystonia
☐ Pelvic Thrust
☐ Other _____

Comments _____

HIPS

Position



☐ Neutral ☐ ABduct ☐ ADduct

☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

Windswept

☐ WFL ☐ Right ☐ Left

☐ Non-Reducible
☐ Partially Reducible
☐ Reducible - correction
↳ ☐ Self ☐ External Force
☐ Tendency away from neutral

Movement – Lower Extremities

☐ Rocks / extends at hip(s)
☐ Kicks into knee extension
☐ Legs push down into footrests
☐ Spasms / tremors with or after movement
☐ Other

Tonal Influence – LEs

☐ WNL
☐ Paralysis
☐ Flaccid
☐ Low Tone
☐ High Tone
☐ Spasticity
☐ Dystonia
☐ Pelvic Thrust
☐ Other _____

Comments _____

Patient Name: _____

POSTURE IN SITTING

KNEES and FEET

Knees

WFL	☐	L	☐	R			
Limitations	☐	L	☐	R			
Non-Reducible	☐	L	☐	R			
Partially Reducible	☐	L	☐	R			
Reducible - correction	☐	L	☐	R			
Tendency away from neutral	☐	L	☐	R			

Edema _____ + L _____ + R

Feet / Ankles

WFL	☐	L	☐	R	Dorsi-Flexed	☐	L	☐	R
Limitations	☐	L	☐	R	Plantar Flexed	☐	L	☐	R
Non-Reducible	☐	L	☐	R	Inversion	☐	L	☐	R
Partially Reducible	☐	L	☐	R	Eversion	☐	L	☐	R
Reducible - correction	☐	L	☐	R	Supination	☐	L	☐	R
Tendency away from neutral	☐	L	☐	R	Pronation	☐	L	☐	R

Edema _____ + L (figure 8 measurement _____ in.) _____ + R (figure 8 measurement _____ in.)

Edema Scale

1 +	Barely detectible
2 +	Slight indentation, 15 sec. to rebound
3 +	Deep Indentation, 30 sec. to rebound
4 +	➢ 30 sec. to rebound

Foot Reflexes

Crossed Extension	☐	L	☐	R
Extensor Thrust	☐	L	☐	R

Comments _____

HEAD and NECK

☐ Neutral
☐ Flexed ☐ Extended
☐ Rotated Left ☐ Rotated Right
☐ Lat Flexed L ☐ Lat Flexed R

☐ Good Head Control
☐ Fair (adequate) Head Control
☐ Poor (limited) Head Control
☐ Absent Head Control
☐ Cervical Hyperextension

☐ Non-Reducible ☐ Partially Reducible ☐ Reducible - correction
☐ Tendency away from neutral ↳ ☐ Self ☐ External force
☐ Asymmetric Tonic Neck Reflex ☐ Symmetric Tonic Neck Reflex

Describe Tone / Movement of the Head / Neck

ARMS

Shoulders

Neutral	☐	L	☐	R
Elevated	☐	L	☐	R
Depressed	☐	L	☐	R
Protracted	☐	L	☐	R
Retracted	☐	L	☐	R
Subluxed	☐	L	☐	R
Rotated	☐	L	☐	R
Non-Reducible	☐	L	☐	R
Partially Reducible	☐	L	☐	R
Reducible - correction	☐	L	☐	R
Tendency a/f neutral	☐	L	☐	R

Elbows / Forearms

Functional	☐	L	☐	R
Flexed	☐	L	☐	R
Extended	☐	L	☐	R
Pronated	☐	L	☐	R
Supinated	☐	L	☐	R
Non-Reducible	☐	L	☐	R
Partially Reducible	☐	L	☐	R
Reducible - correction	☐	L	☐	R
Tendency a/f neutral	☐	L	☐	R

Vertical Reach (in.)

	Left	Right
Sitting	_____	_____
Elevated	_____	_____
Standing	_____	_____

Specific Strength / ROM Issues

Tonal influence - UEs

☐ WFL
☐ Paralysis
☐ Flaccid
☐ Low tone
☐ High Tone
☐ Spasticity
☐ Dystonia
☐ Other

UE Movement / Control ☐ WNL ☐ Good / Functional ☐ Fair / Adequate ☐ Poor / Limited ☐ Absent

Comments _____

Wrists

Neutral	☐	L	☐	R
Flexed	☐	L	☐	R
Extended	☐	L	☐	R
Deviated (describe)	☐	L	☐	R
Non-Reducible	☐	L	☐	R
Partially Reducible	☐	L	☐	R
Reducible - correction	☐	L	☐	R
Tendency a/f neutral	☐	L	☐	R

Hands / Fingers

Neutral	☐	L	☐	R
Flexed	☐	L	☐	R
Extended	☐	L	☐	R
Deviated (describe)	☐	L	☐	R
Non-Reducible	☐	L	☐	R
Partially Reducible	☐	L	☐	R
Reducible - correction	☐	L	☐	R
Tendency a/f neutral	☐	L	☐	R

Handedness ☐ L ☐ R

Grip Strength L _____
Grip Strength R _____
Edema L _____
Edema R _____

Specific Strength / ROM Issues

Describe what has Changed to Require New and/or Different Seating Equipment

Patient Name: _____

MOBILITY EVALUATION

TRANSFERS & AMBULATION

Transfers

- ☐ Independent
- ☐ Standby/Contact Assist
- ☐ Min Assist
- ☐ Mod Assist
- ☐ Max Assist
- ☐ Dependent

☐ Indep. _____ ft. ☐ w/ device ☐ w/o device

Check all that apply

- ☐ Smooth / Level Surfaces
- ☐ Carpet
- ☐ Thresholds
- ☐ Stairs / Curbs
- ☐ Grass / Gravel
- ☐ Ramps / Inclines
- ☐ Uneven Terrain
- ☐ Other _____

Ambulation

☐ Standby Asst/Supervision	☐ w/ device	☐ w/o device
☐ Contact Guard	☐ w/ device	☐ w/o device
☐ Min Physical Asst	☐ w/ device	☐ w/o device
☐ Mod Physical Asst	☐ w/ device	☐ w/o device
☐ Max Physical Asst	☐ w/ device	☐ w/o device

Distance _____ ft.

☐ Dependent / Unable to Ambulate

Transfer Method

- ☐ Stand Pivot
- ☐ Sit/Squat Pivot
- ☐ Sliding Board
- ☐ Lift / Sling Required
- ☐ Uses / requires SE to transfer
- ☐ Recommend transfer training

Timed up and Go Test _____ sec. [60-69 y.o. = 8.1 sec (7.1-9.0), 70-79 y.o. = 9.2 sec (8.2-10.2), 70-99 y.o. = 11.3 sec (10.0-12.7)]

Fall History Number of fall in the past 6 months _____ Number of "near" falls in the past 6 months _____

If ambulation fluctuates explain why

Explain why Patient is Non-Ambulatory or not a Functional Ambulator

- ☐ Cardiac System
- ☐ Circulatory System
- ☐ Musculoskeletal System
- ☐ Neuromuscular System
- ☐ Pulmonary System
- ☐ _____

Comments

WHEELCHAIR SKILLS (Shown by Trial)

	Indep.	Assist	Dep / Unable	N/A*				
Manual W/C Propulsion	☐	☐	☐	☐	☐ Safe	☐ Timely	Distance _____	ft.

Device trialed _____

☐ *MWC ruled out due to (below)

- ☐ Inability to perform repetitive motion to self-propel
- ☐ Medically contraindicated
- ☐ Other _____

- ☐ Able to propel the MWC forward
- ☐ Able to propel the MWC in reverse
- ☐ Able to propel the MWC turning left/right
- ☐ Recommend MWC skills training
- ☐ Recommend MWC with power assist device**
- ☐ Recommend dependent MWC (stroller / tilt in space)

Method

Arm ☐ Left ☐ Right ☐ Both

Leg ☐ Left ☐ Right ☐ Both

Comments

Adjustable Axle Position ☐ Vertical (100° - 120° elbow flexion) ☐ Horizontal (distance per push / w/c skills) ☐ Rotational (lateral stability)

****Operate Power Assist Device**

Device Trialed _____ _____

Comments

	Indep.	Assist	Dep / Unable	N/A*				
Operate Scooter (POV)	☐	☐	☐	☐	☐ Safe	☐ Timely	Distance _____	ft.

Device trialed _____

☐ *POV ruled out die to (below)

- ☐ Inability to transfer indep.
- ☐ Inability to sit in / use POV
- ☐ Inability to operate the tiller
- ☐ Home does not support its use
- ☐ Other _____

- ☐ Able to operate the POV forward
- ☐ Able to operate the POV in reverse
- ☐ Able to operate the POV turning left/right
- ☐ Able to transfer to/from POV independently
- ☐ Able to sit on and operate POV independently
- ☐ Recommend POV skills training

Comments

	Indep.	Assist	Dep Unable	N/A*				
Operate PWC	☐	☐	☐	☐	☐ Safe	☐ Timely	Distance _____	ft.

Device trialed _____

☐ *PWC ruled out due to (below)

- ☐ Lower lever equip. meets needs
- ☐ Cognitively unable to operate
- ☐ Physically unable to operate
- ☐ Home does not support its use
- ☐ Other _____

- ☐ Able to operate the PWC forward
- ☐ Able to operate the PWC in reverse
- ☐ Able to operate the PWC turning left / right
- ☐ Recommend PWC skills training
- ☐ Recommend PWC for caregiver operation (unable to push MWC)

Comments

Patient Name: _____

EQUIPMENT TRIAL(S) and RESULTS

Summary: The least costly mobility device required for safe, functional, and independent mobility was found to be:

☐ Crutch / Cane ☐ Walker ☐ Dependent care mobility device (stroller / tilt-in-space) ☐ Std. MWC ☐ Ultralight MWC ☐ MWC w/ power assist device
☐ Scooter (POV) ☐ Std. PWC ☐ Standard PWC w/ SE ☐ Complex Rehab PWC ☐ Complex Rehab PWC w/ power seat function(s)

GOALS for SEATING and WHEELED MOBILITY INTERVENTION

Goals for Mobility Base (check all that apply)

☐ Maximize independence with mobility in the home to perform/participate in ADLs
☐ Maximize independence with mobility at school, work and/or in the community
☐ Dependent mobility for safe transport
☐ Support ability to live in the community / least restrictive environment
☐ _____
☐ _____

Goals for Manual / Power Seat Functions (check all that apply)

☐ Provide posterior tilt to facilitate pressure relief / re-distribution, postural control, and/or physiological functioning
☐ Provide recline to facilitate pressure relief / re-distribution, postural control, physiological functioning, and/or ADL care
☐ Provide seat elevation to facilitate safe, timely, and/or independent transfers
☐ Provide seat elevation to facilitate reach and performance of / participation in ADLs
☐ Provide anterior tilt to facilitate reach and performance of / participation in ADLs
☐ Provide power standing to facilitate pressure relief / re-distribution
☐ Provide power standing to facilitate reach and performance of / participation in ADLs
☐ Provide power standing to facilitate improve lower limb functioning, ROM, bone health, and/or physiological functioning
☐ Improve physiological processes such as breathing, chewing / swallowing, digestion, and/or bowel / bladder function / care
☐ Realign posture and enhance function
☐ Re-distribute / relieve pressure
☐ Enhance visual orientation / line of sight
☐ Manage orthostatic hypotension and/or autonomic dysreflexia
☐ Improve transfer biomechanics, safety, and/or independence
☐ Manage / regulate tone and/or spasticity
☐ Accommodate / prevent contractures and/or orthopedic deformities
☐ Improve circulation and/or manage edema
☐ Promote dynamic movement
☐ Maximize sitting tolerance and use of wheelchair
☐ Manage pain
☐ Facilitate reach biomechanics, safety, and/or range
☐ Promote communication, engagement, arousal, and/or alertness
☐ Minimize risk for adverse occurrences, medical complications, and/or injury
☐ _____
☐ _____
☐ _____
☐ _____

Goals for Seating and Positioning (check all that apply)

☐ Provide skin protection / pressure re-distribution to minimize risk of pressure injury
☐ Provide pressure re-distribution to promote wound healing
☐ Maximize sitting tolerance and use of wheelchair
☐ Provide postural support in conjunction with tilt and/or recline
☐ Provide postural support due to asymmetry and/or postural anomaly(ies)
☐ Provide postural support needed to facilitate function and/or safety
☐ Provide corrective / supportive force(s) to assist with maintaining and/or improving posture
☐ Accommodate client's posture - current seated postures and positions are not reducible or will not tolerate corrective forces
☐ _____
☐ _____
☐ _____

Patient Name: _____

MOBILITY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

		JUSTIFICATION	
Manufacturer	_____	☐ Provide transport from point A to B	☐ Width / depth necessary to accom. anatomical meas.
Model	_____	☐ Non-ambulatory / cannot walk	☐ Decrease caregiver burden
Color	_____	☐ Not a safe, timely, and/or independent ambulator	☐ Minimize risk for medical complications
Seat Width	_____	☐ Cane or walker inadequate	☐ Minimize risk for an adverse occurrence
Seat Depth	_____	☐ Promote safe, timely, and/or independent mobility	☐ Minimize risk for injury
Seat - Floor Height	_____	☐ Support ability to live in the community vs. institution	☐ Maximize independence and self-determination
Can be grown	_____	☐ Equipment is a lifetime medical need	☐ _____
Length of need	_____		

MANUAL MOBILITY BASE	JUSTIFICATION	
☐ **Not Applicable**		
☐ **Adaptive Stroller Base**	☐ Infant / child ☐ Unable to propel MWC / not appropriate at this time ☐ Independent mobility is not a goal currently ☐ _____	☐ Non-functional ambulator ☐ Non-functional UE ☐ Unable to safely operate PMD / not appropriate at this time ☐ _____
☐ **Travel Base** ☐ **Dependent Base** ☐ **Standard Manual Wheelchair**	☐ Non-ambulatory / cannot walk ☐ Not a safe, timely, and/or independent ambulator ☐ _____	☐ Unable to self-propel in residence ☐ Able to self-propel in residence ☐ _____
☐ **Lightweight Manual Wheelchair**	☐ Medical condition / weight of w/c affect ability to self-propel standard MWC ☐ Seat to floor height required to self-propel w/ foot/feet ☐ _____	☐ Can and does use the w/c for ADLs ☐ Willing and motivated to use
☐ **High-strength Lightweight MWC** ↳ ☐ **Hemi-height** ↳ ☐ **Super hemi-height**	☐ Medical condition / weight of w/c affect ability to self-propel standard MWC ☐ Requires a specific seat width, depth, and/or height or additional features not available on other MWCs ☐ Full-time daily use (> 2 hours / day) ☐ Seat to floor height required to self-propel w/ foot/feet ☐ Different front/rear seat ht. for postural stability/function	☐ Can and does use the w/c for ADLs ☐ Willing and motivated to use ☐ _____
☐ **Ultra-lightweight MWC** Axle Position Adjustment Required **Vertical** ☐ UE biomechanics (100° - 120° elbow flexion) ☐ Seat slope for propulsion, balance and/or pelvic stability **Horizontal** ☐ Stroke length ☐ Reduce weight on casters ☐ Decrease footprint of w/c for increased maneuverability **Rotational** ☐ Lateral stability ☐ UE grip for propulsion	☐ Full-time manual w/c user requiring individualized fitting and adjustments for multiple features that cannot be provided on a standard, lightweight or high-strength lightweight w/c ☐ Improved UE access to wheels ☐ Reduce UE overuse injury ☐ Improve postural stability in w/c by changing axle position ☐ Increase propulsion efficiency by changing axle position ☐ Increase ability to perform high-level wheelchair skills ☐ Changes in seat to back angle for postural stability/function ☐ Allow for growth (width) adjustability ☐ _____	☐ Full-time w/c user for all ADLs ☐ Willing and motivated to use ☐ Required to load w/c into vehicle ☐ _____ ☐ **Carbon Fiber/Magnesium/Titanium Construction** ☐ _____ ☐ _____ ☐ _____
☐ **Heavy-duty MWC** ☐ **Extra Heavy-duty MWC**	☐ Accommodate user weight ☐ Broken frame on previous chair	☐ Extreme tone and/or excessive movement ☐ _____
☐ **Power Assist Device on MWC**	☐ Required to conserve energy to perform or participate in ADLs ☐ Cannot functionally operate a manual wheelchair ☐ Minimize shoulder pain during MWC propulsion ☐ Repetitive strain injury in shoulder girdle ☐ Unable to propel long distances throughout the day ☐ Unable to propel up ramps / inclines without it	☐ Has been using ultralight w/c base more than a year ☐ Home or transportation does not accommodate a PWC ☐ Unable / unwilling to use power w/c ☐ Less expensive option to PWC ☐ _____

Patient Name: _____

MOBILITYY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

POWER MOBILITY BASE	JUSTIFICATION	
☐ **Not Applicable**		
☐ **Scooter / POV**	☐ Non-ambulatory / cannot walk	☐ Can safely transfer to/from it
☐ **3 - wheel**	☐ Not a safe, timely, and/or independent ambulator	☐ Has adequate balance, strength, and ROM to use
☐ **4 - wheel**	☐ Cannot functionally propel MWC	☐ Willing and motivated to use
☐ _____	☐ Conserve energy to perform/participate in ADLs	☐ Home environment supports use
	☐ _____	☐ _____
☐ **Basic / Standard (Group 1/2) PWC**	☐ Non-ambulatory / cannot walk	☐ Requires speed adjustability
☐ **Complex Rehab (Group 3) Power Wheelchair**	☐ Not a safe, timely, and/or independent ambulator	☐ Requires torque adjustability
↳ ☐ Required for suspension to	☐ Cannot functionally propel MWC	☐ Requires braking adjustability
↳ ☐ Minimize pain	☐ Cannot functionally and/or safely operate scooter/POV	☐ Requires expandable electronics
↳ ☐ Manage tone/spasticity	☐ Home environment doesn't support use of a scooter/POV	☐ Requires acceleration adjustability
↳ ☐ Mitigate reflex activity	☐ Requires power seating components	☐ Requires sensitivity adjustability
↳ ☐ Maintain balance/upright sitting	☐ Requires an alternative drive control	☐ _____
↳ ☐ Maintain posture/position/head control	☐ Willing and motivated to use	☐ Required to negotiate an incline of _____ °
↳ ☐ Maintain contact with drive control	☐ Home environment supports use	☐ Required to negotiate obstacles/threshold of _____ "
↳ ☐ _____	☐ Can safely transfer/be transferred	☐ Required to traverse distances/terrain
☐ **High Activity (Group 4) PWC**	☐ _____	☐ _____
☐ **Pediatric (Group 5) PWC**	☐ _____	☐ _____

PWC ELECTRONICS	JUSTIFICATION	
☐ **Not Applicable**		
☐ **Proportional Drive Control**	☐ Best location(s) for repeatable and/or sustainable control / operation of the PWC	
↳ Type _____	☐ Independent PWC operation	☐ Requires reduced or increased force to operate
↳ Body Part(s) _____	☐ Safest means to operate the PWC	☐ Requires reduced throw to operate
☐ Right ☐ Left ☐ N/A	☐ _____	☐ _____
☐ **Non-proportional Drive Control**	☐ Best location(s) for repeatable and/or sustainable control / operation of the PWC	
↳ Type _____	☐ Combination system needed as no single system allows for full control	
↳ Body Part(s) _____	☐ Lacks motor control to operate proportional drive	☐ _____
☐ Right ☐ Left ☐ N/A	☐ Unable to understand proportional control	☐ _____
↳ Body Part(s) _____	☐ Independent PWC operation	☐ _____
☐ Right ☐ Left ☐ N/A	☐ Safest means to operate the PWC	☐ _____
☐ **Upgraded/ /Expandable Electronics**	☐ Required to operate three (3) or more medically necessary power actuator motors through switches or drive control	
	☐ Non-standard proportional joystick	☐ Attendant control
	☐ Alternative proportional drive control	☐ Other electronic devices / assistive technology
	☐ Non-proportional drive control	☐ Operate power seat functions through drive control
☐ **High-powered Wire Harness**	☐ Required for use with expandable electronics	☐ _____
☐ **Single / Mulitple Actuator Control Module**	☐ Required to operate power seat function(s) through the drive control device	
	☐ Uses a joystick and is unable to operate a switch throughout the full range of tilt and/or recline	
	☐ Lacks motor control to consistently activate switch(es) for use with power actuator motors	
	☐ _____	
	☐ _____	
☐ **Display Box**	☐ Required for use with alternative drive controls to allow user to see which mode and/or drive profile the w/c is in	
☐ **Specialty Joystick Handle**	☐ To operate the drive control device	☐ For use with sip and puff system
☐ **Sip and Puff Tubing Kit**	☐ Insufficient hand control for standard joystick handle	☐ For use with chin drive system
☐ **Chin Cup**	☐ _____	☐
☐ **Tracking Electronics / Technology**	☐ Increase efficiency / decrease energy expenditure to drive over thresholds and uneven surfaces	
	☐ Minimize excessive drive commands and the need to self-correct direction	
	☐ Lack of [select below] to make constant corrections to safely progress in a straight line forward	
	↳ ☐ Strength ☐ Endurance ☐ Coordination	☐ _____
	☐ Increase safety while driving	☐ _____

Patient Name: _____

MOBILITYY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

PWC ELECTRONICS	JUSTIFICATION
☐ **Attendant Controlled Joystick and Mount**	☐ Allow caregiver to control wheelchair in case of medical emergency or chair malfunction ☐ User is no longer able to operate drive control device throughout the day ☐ Allow age/developmentally appropriate assistance when driving ☐ User requires assistance for safety in unfamiliar environments ☐ Compliance with transportation regulations ☐ _____
☐ **Safety Reset Switches**	☐ To change modes / stop when chair is latched ☐ _____
☐ **Swing-away Mount for Joystick**	☐ For safe transfers ☐ _____
☐ **Batteries**	☐ Required to provide power to the motors on PMD ☐ Lithium ion for all-day use ☐ _____ ☐ Lithium ion for travel
☐ **Battery Charger**	☐ Charge battery for wheelchair ☐ _____
☐ **Other** _____	☐ _____
☐ **Other** _____	☐ _____

SEAT FUNCTIONS / POSITION CHANGES	JUSTIFICATION
☐ **Not Applicable**	
☐ **Posterior Tilt Base or Tilt Feature Added** ↳ ☐ Powered tilt on power chair ↳ ☐ Powered tilt on manual chair ↳ ☐ Manual tilt on manual base ↳ ☐ Manual tilt on power base	☐ Change position against gravitational force on head / trunk ☐ Change position for pressure redistribution / cannot weight shift ☐ Improve chewing, swallowing and/or digestion ☐ Rest periods / inability to transfer out of chair for rest ☐ Minimize risk of aspiration ☐ Manage tone / spasticity ☐ Assist / maintain postural alignment ☐ Decrease respiratory distress ☐ Facilitate visual orientation ☐ Manage autonomic dysreflexia ☐ Decrease pain ☐ Facilitate postural control ☐ Manage orthostatic hypotension ☐ Blood pressure management ☐ Maintain vital organ capacity ☐ Increase sitting tolerance ☐ Facilitate safe transfers ☐ _____ ☐ _____ ☐ Use in conjunction with recline for optimal pressure re-distribution as recline alone does not accomplish effective pressure relief / tissue perfusion
☐ **Recline** ↳ ☐ Semi (> 15° but < 80°) ☐ Full (> 80°) ↳ ☐ Power recline on power chair ↳ ☐ Power recline on manual chair ↳ ☐ Manual recline on manual base ↳ ☐ Manual recline on power base	☐ Manage bowel/bladder/catheter care, intermittent catheterization, undergarment, change ☐ Use in conjunction with elevating leg rests to raise LE above heart to manage edema ☐ Full pressure redistribution/cannot weight shift ☐ Recumbent rest periods and sleeping in wheelchair ☐ Accommodate femur to back angle ☐ Maintain muscle length/ ROM ☐ Minimize orthopedic deformity ☐ Head/neck positioning/support ☐ Repositioning ☐ Participation in ADL care ☐ Manage tone/spasticity ☐ Increase sitting tolerance ☐ Facilitate postural control ☐ Blood pressure management ☐ Improve circulation ☐ Manage respiratory distress ☐ Facilitate safe transfers ☐ Decrease pain ☐ ☐ Use in conjunction with tilt for optimal pressure re-distribution as tilt alone does not accomplish effective pressure relief / tissue perfusion
☐ **Power Anterior Tilt** ☐ **Power Seat Elevation** ☐ **Power Standing Module** ☐ **Power Lateral Tilt** ↳ ☐ Left ☐ Right ☐ Both	☐ Provide pressure distribution away from scapula, sacrum, coccyx, and ischial tuberosities ☐ Minimize over shoulder reach & risk for overuse injury ☐ Drive at elevated height for improved line of sight/safety ☐ Minimize risk of fall/injury in transfers ☐ Improve eye gaze to perform/participate in ADLs ☐ Support educational/vocational goals ☐ Decrease hyper lordotic neck position ☐ Increase independence in ADLs ☐ Increase functional reach ☐ Improve bathroom function and safety ☐ Increase transfer independence ☐ Increase weight bearing on LE ☐ Minimize risk for joint contractures ☐ Minimizing eliciting STNR ☐ Decrease pain ☐ Improve digestion and elimination ☐ _____ ☐ _____ ☐ _____
☐ **Power Leg Elevation** ↳ ☐ Power center mount foot platform ↳ ☐ Power center mount foot platform w/ articulation ↳ ☐ Power CM foot platform w/ articulation to the floor ↳ ☐ Power elevating legrests ↳ ☐ Power elevating legrests w/ articulation	☐ Increase ground clearance over thresholds, curbs, or uneven terrain ☐ Center mount tucks into chair to decrease turning radius in the home - not available with ELRs ☐ Position LEs at 90° when upright, not available with standard power ELRs ☐ Independent operation of ELRs needed, not available with center mount ☐ Physically unable to operate manual elevating leg rests ☐ Elevate LEs during tilt, recline or tilt and recline ☐ Maintain LE muscle length/joint ROM ☐ Maintain feet on footplate ☐ Manage LE edema ☐ Improve circulation ☐ _____

Patient Name: _____

MOBILITY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

MOBILITY BASE COMPONENTS	JUSTIFICATION
☐ **Armrests** ↳ ☐ Fixed height ☐ Adj. height ☐ Reclining ☐ Swing away ☐ Cantilever ☐ Removable ☐ Full length ☐ Desk length ☐ Tubular ☐ _____ ☐ Waterfall arm pad ☐ Gel arm pad	☐ Accommodate seat-elbow measurement ☐ Change height / angle for ADLs ☐ Provide support with elbow at 90° ☐ Remove, swing away, or flip back for transfers ☐ Postural control / trunk support ☐ Access to surfaces for ADLs ☐ Reduce shoulder subluxation ☐ Support UE positioning equipment ☐ Assist with pressure relief ☐ Protect boney prominences at elbow / wrist ☐ Allow UEs to move w/ reclining back ☐ _____
☐ **Foot Platform / Footrests / Leg Rests**	☐ Provide LE support ☐ Maintain feet on footplate(s) ☐ Support seated position
↳ ☐ Center foot platform ☐ _____ ☐ Fixed ☐ Removable ☐ Swing-away ☐ Standard ☐ Tapered ☐ V-style ☐ 60° ☐ 70° ☐ 80° ☐ 90° ☐ Dynamic seating component for knee(s) ☐ _____ ☐ Heavy duty ☐ Manual elevating ☐ Articulating	☐ Used in conjunction with tilt to maintain supported position ☐ Small turning radius for maneuverability ☐ _____ ☐ Remove for foot propulsion ☐ Swing away for access ☐ Swing away/remove for safe transfers ☐ Accommodate LE seated position ☐ Narrow front chair width ☐ _____ ☐ Accommodate knee ROM limitation(s) ☐ Maintain muscle length / joint ROM ☐ Manage tone / spasticity ☐ Provide sensory input ☐ Provide mvmt. to decrease agitation ☐ Absorb forces to prevent loss of seated position ☐ Absorb mvmt. w/o resistance / facilitate movement ☐ Accommodate user weight ☐ _____ ☐ _____ ☐ Used w/ recline to manage edema ☐ Indep. LE positioning R / L ☐ Improve circulation (blood/lymph)
☐ **Foot Plate**	☐ Provide support for foot / feet ☐ Support seated position ☐ _____
↳ ☐ Fixed ☐ Flip up ☐ One piece foot plate ☐ Adjustable angle → ☐ R ☐ L ☐ Multi-adj. angle → ☐ R ☐ L ☐ Dynamic seating component for foot / feet	☐ Move out of the way for safe transfers ☐ Allow foot / feet to go under w/c base ☐ Provide foot support with proper pressure distribution ☐ Prevent foot / feet from falling off foot support ☐ Accommodate ankle ROM ☐ Pressure distribution ☐ Full contact to mitigate foot reflexes ☐ Absorb forces to prevent loss of seated position ☐ Absorb mvmt. w/o resistance / facilitate movement
☐ **MWC Propulsion / PWC Drive Wheel Size** ↳ _____ in. **MWC Spokes** ☐ Standard ☐ Mag ☐ Spinergy	☐ Propulsion biomechanics ☐ Accommodate seat to floor ht. ☐ Allow seating system to fit on base ☐ Larger wheel improves ability to negotiate thresholds / uneven terrain ☐ _____ ☐ Maintenance free ☐ Decrease overall wt. of w/c ☐
☐ **MWC Quick Release Axle**	☐ Allows wheels to be removed to decrease size for storage ☐ Decrease w/c weight for lifting
☐ **MWC Propulsion / PWC Drive Tires** ☐ Solid ☐ Pneumatic ☐ Semi-pneumatic ☐ Flat free inserts ☐ _____	☐ Maneuverability ☐ Stability of the wheelchair ☐ Durability ☐ Decrease rolling resistance ☐ Increase shock absorbency ☐ _____ ☐ Maintenance free/prevent flats ☐ User unable to maintain air in tires
☐ **MWC Wheel Rims / Handrims** ↳ ☐ Metal ☐ Plastic coated ☐ Ergonomic **Projections** → Number _____ ☐ Oblique ☐ Vertical	☐ Provide ability to propel wheelchair ☐ _____ ☐ Reduce / mitigate Carpal Tunnel Syndrome ☐ _____ ☐ _____ ☐ Increase self-propulsion with UE weakness / hand weakness / decreased grasp
☐ **MWC Alternative Propulsion Device** ↳ One arm drive attachment ☐ Right ☐ Left ☐ Linked ☐ Lever activated ☐ Gear reduction	☐ Enable propulsion of manual wheelchair with one arm ☐ Decrease shoulder pain ☐ Functional use of only one UE ☐ _____ ☐ Increase energy efficiency for self-propulsion ☐ _____
☐ **MWC Spoke Guard / Protectors**	☐ Protects hands / fingers from injury ☐ _____
☐ **MWC Wheel Locks** ↳ ☐ Push ☐ Pull ☐ Scissor ☐ Hub style ☐ Foot lock ☐ Extension → ☐ R ☐ L	☐ Stabilize wheel for transfers ☐ Lock wheels to prevent rolling ☐ _____ ☐ Wheel clearance in unlocked position to prevent injury during propulsion ☐ _____ ☐ _____ ☐ Independence in applying wheel lock due to decreased reach or strength ☐ _____
☐ **MWC Amputee Adapter**	☐ Unable to counterbalance w/c due to loss of LE ☐ Increase rearward stability of w/c
☐ **MWC Anti- Rollback Device**	☐ Prevent w/c from rolling backwards while moving forward while ascending ramps ☐ _____
☐ **MWC Side Guards**	☐ Prevent body parts from becoming caught in wheel causing injury ☐ _____ ☐ Prevent skin tears / abrasions ☐ Provide hip and pelvic stabilization
☐ **WC Anti-Tipping Device**	☐ Minimize risk for rearward displacement / tipping ☐ Minimize risk for forward displacement / tipping
☐ **WC Transit Tie Down / Locking System**	☐ Crash-tested brackets for safe transport ☐ Docking system for safe transport
☐ **Specific Seat Height** ↳ Front _____ Back _____	☐ Foot propulsion ☐ Transfers ☐ Postural stability ☐ Accommodate lower leg length ☐ _____ ☐ _____
☐ **Casters** → Size _____ ↳ ☐ Fixed caster housing ☐ Adj. caster housing	☐ Keep user weight evenly distributed for decreased energy expenditure ☐ Angle adj. for postural control ☐ Increase leverage for improved obstacle and transition management ☐ Accommodate seat to floor height

Patient Name: _____

MOBILITY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

MOBILITY BASE COMPONENTS	JUSTIFICATION
☐ **Caster Tires** ↳ ☐ Solid ☐ Pneumatic ☐ Semi-pneumatic ☐ Poly ☐ Soft roll ☐ Flat free inserts ☐ _____	☐ Maneuverability ☐ Stability of the wheelchair ☐ Durability ☐ Decrease rolling resistance ☐ Increase shock absorbency ☐ _____ ☐ Decrease spasms / spasticity ☐ Decrease pain ☐ _____ ☐ Maintenance free/prevent flats ☐ User unable to maintain air in tires
☐ **Shock Absorbers / Suspension**	☐ Decrease spasms / spasticity ☐ Decrease pain ☐ Decrease vibration ☐ Increase sitting tolerance ☐ Decrease fatigue ☐ _____
☐ **Rear Cane / Push Handles** ☐ Standard ☐ Extended ☐ Adjustable Angle ☐ Dynamic	☐ Allows "hooking" to maintain balance, perform pressure relief and / or participate in ADLs ☐ Caregiver access to push w/c ☐ Caregiver assist up/down curbs ☐ _____ ☐ _____ ☐ _____
☐ **Angle Adjustable Back**	☐ Postural control ☐ Accommodate available ROM ☐ Control tone / spasticity
☐ **Depth Adjustable Back**	☐ Allow growth of system ☐ Accommodate available ROM ☐ _____
☐ **Height Adjustable Back**	☐ Postural control ☐ Promote UE function ☐ _____
☐ **Canopy**	☐ User has light sensitivity ☐ Regulate sensory input ☐ Protect user from the elements
☐ **Cane / Crutch Holder** ☐ **IV Hanger**	☐ User is dependent on device ☐ _____ ☐ _____
☐ **O_2 Holder**	☐ User is dependent on device ☐ _____ ☐ _____
☐ **Ventilator Tray** ↳ ☐ Fixed ☐ Gimbled ☐ _____	☐ User is dependent on device ☐ Stabilize ventilator on wheelchair ☐ _____ ☐ _____
☐ **Lights**	☐ Safe operation within the home once dwelling lights are turned off ☐ _____ ☐ Increase visibility at night and/or during inclement weather ☐ Increased safety while crossing street
☐ **Essential Needs Bag / Pouch** Required to hold / provide access to medically necessary	☐ Diapers / Undergarments ☐ Catheter / hygiene supplies ☐ Ostomy / hygiene supplies ☐ Medicine ☐ Special food ☐ Orthotics / Prosthetics ☐ Clothing for changes / weather ☐ _____

SEATING & POSITIONING EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

COMPONENT	MFG / MODEL / SIZE	JUSTIFICATION
☐ **Seat Cushion** ↳ ☐ General use ☐ Skin protection ☐ Positioning ☐ Skin protect/position ☐ Adjustable ☐ Custom		☐ Support in sitting ☐ Absent / impaired sensation ☐ High risk for pressure injury ☐ Pressure injury present ☐ History of pressure injury ☐ Pressure distribution / tissue perfusion ☐ Stabilize pelvis in neutral ☐ Accommodate postural asymmetry ☐ Accommodate post. pelvic tilt ☐ Accommodate ant. Pelvic tilt ☐ Accommodate pelvic obliquity / rotation ☐ Accom. multiple deformities ☐ Support LE positioning ☐ _____ ☐ Requires protective material to move with user to maintain full contact ☐ _____ ☐ Commercially available cushion cannot accommodate deformity/shape ☐ _____
☐ **Seat Pan/Solid Insert**	_____	☐ Accommodate seat to floor height ☐ Attach cushion to base ☐ Prevent hammocking of w/c upholstery
☐ **Seat Wedge**	_____	☐ Accommodate ROM limitations ☐ Aggressive seat shape to minimize sliding down in / out of w/c
☐ **Replacement Cover**	_____	☐ Protect back and/or seat cushion ☐ _____
☐ **Back Cushion** ↳ ☐ General use ☐ Posterior ☐ Posterior-lateral ☐ Planar ☐ Custom		☐ Support in sitting ☐ Provide posterior support ☐ Provide posterior and lateral support ☐ Support/stabilize trunk in midline ☐ Facilitate UE movement ☐ _____ ☐ Accommodate postural deformity ☐ Accom/reduce scoliosis lean ☐ Accom/reduce thoracic kyphosis ☐ Provide lumbar / sacral support ☐ Minimize pelvic rotation ☐ Minimize posterior pelvic tilt ☐ Accommodate / decrease tone ☐ Facilitate tone/postural control ☐ Pressure relief over spinous processes ☐ Commercially available cushion cannot accommodate deformity/shape ☐ _____
☐ **Back Pan / Solid Insert**	_____	☐ Accommodate seat depth ☐ Attach cushion to w/c back ☐ Prevent hammocking of w/c upholstery

Additional Information for Wheelchair Cushion and Back

Patient Name: _____

SEATING & POSITIONING EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

COMPONENT	MFG / MODEL / SIZE	JUSTIFICATION	
☐ **Anterior Pelvic Support** ↳ ☐ Pelvic belt / strap ☐ Specialty pelvic support system ☐ Padded ☐ Other _____ ☐ SubASIS bar ☐ Other _____		☐ Stabilize the pelvis in neutral ☐ Promote anatomical alignment ☐ Maintain contact with the seat cushion ☐ Mitigate posterior pelvic tilt ☐ Reduce anterior pelvic tilt	☐ Pelvic de-rotation / spinal alignment ☐ Neutralize pelvic obliquity ☐ Proximal stability for distal function ☐ Protect boney prominences ☐ _____
☐ **Lateral Pelvic Support** ↳ ☐ Right ☐ Left		☐ Stabilize pelvis in neutral position ☐ Accommodate tone	☐ Accom. pelvic asymmetry / deformity ☐ _____
☐ **Lateral Pelvic Support Hardware** ↳ ☐ Fixed ☐ Swing-away / removable		☐ Remove / swing-away for safe transfers ☐ _____	☐ _____ ☐ _____
☐ **Lateral Thigh / Knee Support** ↳ ☐ Right ☐ Left		☐ Position thighs in neutral alignment ☐ Accommodate tone ☐ _____	☐ Decrease LE abduction ☐ Accommodate windswept deformity ☐ _____
☐ **Lateral Thigh / Knee Support Hardware** ↳ ☐ Fixed ☐ Swing-away / removable		☐ Remove / swing-away for safe transfers ☐ _____	☐ _____ ☐ _____
☐ **Medial Thigh / Knee Support**		☐ Position thighs in neutral alignment ☐ Accommodate tone ☐ _____	☐ Decrease LE adduction ☐ Accommodate windswept deformity ☐ _____
☐ **Medial Thigh / Knee Support Hardware** ↳ ☐ Fixed ☐ Swing-away / removable		☐ Remove / swing-away for safe transfers ☐ _____	☐ _____ ☐ _____
☐ **Residual Limb Support** → ☐ R ☐ L		☐ Support residual limb	☐ Position limb in neutral alignment
☐ **Foot Support** ↳ ☐ Foot box → ☐ Both ☐ R ☐ L ☐ Shoe holder → ☐ R ☐ L		☐ Position foot/feet in neutral alignment ☐ Accommodate deformity ☐ Minimize extraneous mvmt/injury risk	☐ Stabilize sitting base of support ☐ Decrease tone / foot reflexes ☐ _____
☐ **Leg / Foot Straps** ↳ ☐ Calf strap ☐ Heel loop(s) → ☐ R ☐ L ☐ Ankle strap(s) → ☐ R ☐ L ☐ Toe strap(s) → ☐ R ☐ L		☐ Support foot / feet on foot support ☐ Position foot / feet ☐ Decrease extraneous movement ☐ Provide input to ball of foot / feet ☐ _____	☐ Protect foot / feet ☐ Inhibit abnormal tone patterns ☐ Increase postural stability ☐ Provide input to heel ☐ _____
☐ **Dynamic Seating Component for Hips / Back** ☐ **Specialty Back System for Postural Control**		☐ Absorb forces to minimize risk for injury ☐ Provide outlet for tone / spasticity ☐ Provide mvmt. to decrease agitation ☐ Provide sensory input ☐ Support functional reach ☐ Provide pelvic stability w/ trunk mobility ☐ _____	☐ Absorb forces to maint. seated position ☐ Support mvmt. / trunk ROM / control ☐ Increase alertness / arousal ☐ Minimize fatigue / incr. sitting tolerance ☐ Diffuse force against w/c back ☐ Participate in / perform ADLs ☐ _____
☐ **Lateral Thoracic Support** ↳ ☐ Right ☐ Left		☐ Decrease destructive postural tendency ☐ Accommodate asymmetry / scoliosis ☐ Control tone / spasticity ☐ Curved for increased contact ☐ _____	☐ Decrease trunk leaning / poor balance ☐ Specific support for midline positioning ☐ Provide core stability for function ☐ Anterior / lateral for increased stability ☐ _____
☐ **Lateral Thoracic Support Hardware** ↳ ☐ Fixed ☐ Swing-away / removable		☐ Remove / swing-away for safe transfers ☐ _____	☐ _____ ☐ _____
☐ **Anterior Chest Support** ↳ ☐ Anterior chest strap ☐ Anterior chest harness ☐ Shoulder harness ☐ Shoulder retractors ☐ Other _____		☐ Decrease forward movement of trunk ☐ Increase trunk stability ☐ Accommodate / facilitate movement ☐ Assist with shoulder control ☐ Decrease forward mvmt. of shoulders ☐ _____	☐ Support anterior / posterior alignment ☐ Provide core stability for function ☐ Accommodate TLSO ☐ Decrease shoulder elevation ☐ _____

Patient Name: _____

SEATING & POSITIONING EQUIPMENT RECOMMENDATIONS & JUSTIFICATION

COMPONENT	MFG / MODEL / SIZE	JUSTIFICATION
☐ **Upper Extremity Support** ☐ Full tray ☐ Joystick cutout ☐ Half tray → ☐ R ☐ L ☐ Arm trough → ☐ R ☐ L ☐ Hand support → ☐ R ☐ L ☐ Elbow block → ☐ R ☐ L ☐ Wrist strap → ☐ R ☐ L		☐ Support midline trunk positioning ☐ Provide support for UE function ☐ Decrease gravity's pull on shoulders ☐ Proper tray placement w/o interference ☐ Minimize shoulder subluxation ☐ Support flaccid UE(s) ☐ Minimize extraneous mvmt. and injury ☐ Control tone / spasticity ☐ Maintain hand in neutral position ☐ _____ ☐ Prevent UEs from falling off armrests / UE support during tilt and/or recline ☐ _____ ☐ _____
☐ **Upper Extremity Support Mounting Hardware** ☐ Fixed ☐ Swing-away / removable ☐ Swivel ☐ Elevating-swivel		☐ Remove / swing-away for safe transfers ☐ _____ ☐ UE alignment at shoulder ☐ _____ ☐ Decrease edema ☐ _____
☐ **Head Support** ☐ Posterior head pad ☐ Contoured headrest ☐ Posterior-lateral head support system ☐ Lateral head support → ☐ R ☐ L ☐ Facial support → ☐ R ☐ L ☐ Anterior head support / strap		☐ Provide posterior support for the head ☐ Head support during tilt and/or recline ☐ Provide posterior-lateral support ☐ Support midline head positioning ☐ Provide lateral head support ☐ Provide anterior head support ☐ Accommodate ROM limitations ☐ Mitigate tone / neck reflex activity ☐ Improve chewing / swallowing ☐ Improve respiration ☐ Visual / auditory access to environment ☐ _____
☐ **Occipital / Neck Support** ☐ Occipital support ☐ Neck support ☐ Occiput-lateral support → ☐ R ☐ L ☐ Neck and anterior chest support system		☐ Decrease neck rotation ☐ Decrease forward neck flexion ☐ Mitigate tone / neck reflex activity ☐ Supported neck movement / control ☐ _____ ☐ _____ ☐ _____ ☐ _____
☐ **Head / Neck Support Hardware** ☐ Fixed ☐ Swing-away / removable ☐ Multi-axis ☐ _____ ☐ Dynamic seating component for head		☐ Remove / swing-away for safe transfers ☐ _____ ☐ UE alignment at shoulder ☐ _____ ☐ Decrease edema ☐ _____ ☐ Absorb forces to prevent loss of seated position

This section was completed by (check all that apply) ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document

Follow-up / Plan of Care

Patient Name Printed _____ Date _____ Patient / Caregiver Signature

Caregiver Name _____ Relation to Pt. _____

☐ I, the above signed patient, certify that I am willing and able to use the recommended equipment

Therapist Name Printed _____ Therapist Signature

License # _____ Date _____

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

☐ None ☐ DME Supplier ☐ Equip. MFG ☐ Patient's LTCF ☐ Other _____ _____

☐ I certify the evaluation was conducted and documented in collaboration with the supplier / ATP below, accurately reflects the patient's equipment needs, and the justification for it.

Supplier Name Printed _____ Supplier Signature

ATP # _____ Date _____

This is to certify that I, the above signed supplier/ATP ☐ Did not complete any part of this document ☐ Only completed sections of this document permissible for supplier use

☐ I, below signed physician, concur with the above findings and recommendations of the therapist and supplier

Physician Name Printed _____ Physician Signature

NPI # _____ Date _____