UPMC Presbyterian
Center for Assistive Technology

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MOBILITY ASSISTIVE EQUIPMENT
CLIENT EVALUATION & IN-TAKE FORM

Therapy Evaluation Date: _____
Physician Face to Face Evaluation Date: _____
Home Evaluation Date: _____
Specifications Received from Supplier: _____
Date Letter Completed: _____

1. PRE-ASSESSMENT SCREENING:

NAME:
_____

MEDICAL RECORDNUMBER:
_____

ADDRESS:
_____

TELEPHONE NUMBER:
_____

DATE OF BIRTH:
_____

AGE:
_____

PRIMARY DIAGNOSES:
_____
_____

SECONDARY DIAGNOSES:
_____
_____
_____

INSURANCE #1:

_____

INSURANCE #2:

_____

REFERRAL SOURCE:

_____

PRIMARY CARE PHYSICIAN & ADDRESS:

_____

_____

_____

REASON FOR REFERRAL:

_____

TYPE OF CURRENT MAE:

_____

_____

_____

HOURS PER DAY USING CURRENT MAE:

_____

AGE OF MAE:

_____

PROBLEMS WITH CURRENT MAE:

_____

_____

_____

HEIGHT:

_____

WEIGHT:

_____

PREFERRED SUPPLIER:

_____

TRANSPORTATION RESOURCES:

_____

_____

LIVING SITUATION:

_____

_____

_____

2. THERAPY FACE TO FACE ASSESSMENT:

Mobility Related ADL STATUS:

- **Bathing:** _____
- **Hygiene:** _____
- **Dressing:** _____
- **Self-Feeding:** _____

Instrumental ADL Status: _____ _____ _____

- **Meal Preparation:** _____
- **Housecleaning:** _____
- **Managing Finances:** _____
- **Shopping:** _____
- **Medication Management:** _____
- **Laundry:** _____
- **Care of Others:** _____

Transfer Status: _____

Weight Shift: _____

Functional Mobility: _____

Community Mobility: _____

Cognition: _____

Leisure Interests: _____

Home Accessibility: _____ _____ _____

Functioning Everyday with a Wheelchair (FEW) TOOL

DIRECTIONS TO CLIENT: Please tell me your level of agreement that best matches your ability to function with your current Mobility Assistive Equipment. All examples may not apply to you, and there may be tasks you perform that are not listed. (Go to www.few.pitt.edu for additional instructions if necessary as this is a self-rapport questionnaire)

6= completely agree
5= mostly agree
4= slightly agree
3= slightly disagree
2= mostly disagree
1= completely disagree
0= does not apply

1. The ***stability, durability, and dependability*** features of my wheelchair/scooter contribute to my ability to carry out my daily routines as independently, safely, and efficiently as possible	***
Comments:	
2. The size, fit, postural support and functional features of my wheelchair/scooter match my ***comfort needs***	
Comments:	
3. The size, fit, postural support and functional features of my wheelchair/scooter match my ***health needs***	
Comments:	
4. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***operate*** it as independently, safely, and efficiently as possible	
Comments:	
5. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***reach*** and carry out tasks at different surface heights as independently, safely, and efficiently as possible	
Comments:	
6. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***transfer*** from one surface to another as independently, safely, and efficiently as possible	
Comment:	
7. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***carry out personal care tasks*** as independently, safely, and efficiently as possible	
Comments:	
8. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***get around indoors*** as independently, safely, and efficiently as possible	
Comments:	

9. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***get around outdoors*** as independently, safely, and efficiently as possible	
Comments:	
10. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***use personal or public transportation*** as independently, safely, and efficiently as possible	
Comments:	

3.THERAPY PHYSICAL MOTOR ASSESSMENT:

UPPER EXTREMITY FUNCTION:

LOWER EXTREMITY FUNCTION:

POSTURE (SITTING & SUPINE):

4. GOALS FOR A NEW SEATING & MOBILITY DEVICE:

1)

2)

3)

4)

5. PHYSICIAN FACE TO FACE ASSESSMENT:

See Attached Physician Note

6. EVALUATION PROCEDURES:

CLINICAL TRIALS/SIMULATION:

Pressure Mapping:

_____
_____
_____
_____
_____

SmartWheel:

_____
_____
_____
_____
_____

Other Tests:

_____
_____
_____
_____
_____

Devices Tried:

_____
_____
_____
_____
_____

Client Impressions:

_____
_____
_____

Home Assessment: See supplier report/attestation.

7. RECOMMENDATIONS:

Mobility Assistive Equipment:

Supplier:

Estimated Length of Need:

INTERVENTION & SPECIFICATION	JUSTIFICATION
Seat	
Seat Frame or Seat Function	
Seat Frame or Seat Function	
Lap Belt	
Thigh Guides /Abductor Wedge	
Leg /Foot Support-	

Back Support-	
Head Support	
Arm Support-	
Tires /Casters	
Wheel-Locks /Anti-tippers	
Tie Downs	
Controller	
Batteries	
Other Feature	
Other Feature	

Other Feature	

IMPLEMENTATION PLAN: The specifications of this prescription will be submitted to _____ primary care physician and insurance carrier for authorization. Upon approval the specifications will be provided by _____ and delivered to the Center for Assistive Technology for fitting and delivery. Upon delivery, the client will be trained in the use of the mobility device and will demonstrate safe and effective use. In addition, he will be given information about its maintenance. Follow-up appointments will be scheduled as needed to modify the equipment as well as to verify that it continues to meet his needs.

This concludes our face to face assessment and we are all in agreement.

_____Date:_____
Therapist Signature

Physician Comments:
_____
_____
_____
_____
_____

_____Date:_____
Physician Signature