

# Wheelchair and Seating Evaluation

To be completed by therapist

## PATIENT INFORMATION

Name	DOB:                      Sex:	Date seen:                      Time:
Address	Physician	<i>This evaluation/justification form will serve as the LMN for the following suppliers:</i> Company Name:  ATP/SMS/Supplier:  Contact at Company:  Phone # supplier:  Phone # company:
	Phone:	
	Evaluating Therapist	
Phone:		
Phone	Primary Therapist: Phone:	
Spouse/Parent/Caregiver name:	1° Insurance/Payor	
Phone number:	Policy #	
	2° Insurance/Payor	
	Policy #	
Referred by: Primary Reason For Referral:		
Client Goals:		
Caregiver goals and specific limitations that may effect care		

## MEDICAL HISTORY

Primary Diagnosis: _____	Code: _____	ONSET: _____
Secondary Diagnosis/Comorbidities/Codes:		
Relevant past and future surgeries: <input type="checkbox"/> Bone <input type="checkbox"/> Skin <input type="checkbox"/> Muscle <input type="checkbox"/> Other		
Height:	Weight:	Explain recent changes or trends in weight in the past 2-5 years
Pertinent Medical History:		

Name:

RIC MR#:

Insurance/recipient #

**Cardio Status:**  Normal  Impaired

Functional Limitations:

**Respiratory Status:**  Normal  SOB  COPD  Vent Dep  O2 Dep  Hx of Chronic Congestion

Functional Limitations:

**Orthotics:**

Amputee  Prosthesis

**HOME ENVIRONMENT**

Setting:  Rural  Urban  Suburban  Paved Roads  Sidewalks  Rough Terrain

House  Condo/town home  Own  Rent  Apartment  Asst Living  LTCF

Lives Alone  Lives with Others (Who?)

Hours with caregiver:

Home is accessible to patient Width of entrance:

Width of bathroom door:

Non-Accessible areas in home:

Level  Stairs  Ramp  Lift/elevator

**Comments:**

When relevant wheelchair cannot exceed:

Width \_\_\_\_\_ Length \_\_\_\_\_ Seat height \_\_\_\_\_ Total height \_\_\_\_\_

**Storage of Wheelchair:**  In home  other (please say where stored)

**COMMUNITY ENVIRONMENT**

**Employment/School**

**Medical Visits**

**Religious Facility/Leisure Environments**

**Other**

Name:

RIC MR#:

Insurance/recipient #

**TRANSPORTATION**

**TRANSPORTATION:**

Car Van SUV/Truck Public Transportation School Bus Van Service Ambulance Other:

**Vehicle Adaptations:**

None Ramp Lift Wheelchair Tie Downs Type: \_\_\_\_\_ Hand Controls Other

**Method of Riding:** Rides in wheelchair Rides in vehicle seat/car seat Self Drives from wheelchair Self drives in driver's seat Other

**Storage:** Where is w/c stored during transport? NA

Size of area needed for transport wxdxh:

If necessary, client or caregiver can load recommended equipment into vehicle: Yes No

**Vehicle Dimensions:**

Door Height                      Inside Height                      Door Width

Ramp WxL    Weight Capacity

**Other:**

**FUNCTIONAL/SENSORY ABILITIES:**

	Appears adequate through observation	Appears impaired through observation	Comments
Attention to environment			
Safety awareness of self and others			
Visual processing skills			
Auditory/Hearing			
Language/Communication			<input type="checkbox"/> Has device-requires mount
Planning and execution			
Behavioral status			

Additional comments regarding processing skills and ability to safely use wheelchair

**PAIN**

PAIN Yes No Location: \_\_\_\_\_ Intensity Scale: (0-10) \_\_\_\_\_

How does pain interfere with mobility and/or ADLs:

Name:

RIC MR#:

Insurance/recipient #

**SENSATION and SKIN INTEGRITY:**

<b>Sensation</b> <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hyposensate <input type="checkbox"/> Hypersensate <input type="checkbox"/> Defensiveness <input type="checkbox"/> Unable to report Level or location of sensation:		<b>Pressure Relief:</b> Able to perform effective pressure relief : <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, method used:  If no, WHY?:	
<b>Skin Integrity</b> Current Skin Issues <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Intact <input type="checkbox"/> Red area <input type="checkbox"/> Open Area   Stage _____ <input type="checkbox"/> Scar Tissue <input type="checkbox"/> At risk from prolonged sitting Location:		<b>History of Skin Issues</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____  When _____ Hx of skin flap surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No Location: _____  When _____	<b>Skin Inspection:</b> <input type="checkbox"/> Indep <input type="checkbox"/> Assisted <input type="checkbox"/> Dep  Method:
<b>Risk factors</b> <input type="checkbox"/> Bony prominences <input type="checkbox"/> Immobility <input type="checkbox"/> Incontinence <input type="checkbox"/> Impaired nutritional or hydration status <input type="checkbox"/> Aging Skin  <input type="checkbox"/> Compromised circulatory status <input type="checkbox"/> Tendency towards moisture buildup (profound perspiration, skin folds)			

**ADL STATUS (in reference to wheelchair use):**

	Indep	Indep with Equip	Assist	Unable	Not assessed	Comments
Dressing						
Eating						Describe oral motor skills (N/A)
Grooming/Hygiene						
Meal Prep						
IADLS: Mobility in the home						
Mobility in the community						
Bowel Mngmnt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents <input type="checkbox"/> Diapers <input type="checkbox"/> Colostomy						
Bladder Mngmnt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents <input type="checkbox"/> Diapers <input type="checkbox"/> Urinal <input type="checkbox"/> Intermittent cath <input type="checkbox"/> Indwelling cath <input type="checkbox"/> Supra-pubic cath						
Number of hours per day spent in wheelchair: _____ Typical Daily Wheelchair Use Schedule:						

Name:

RIC MR#:

Insurance/recipient #

**CURRENT SEATING / MOBILITY:**

**Current Mobility Base:** None Dependent/Travel Dependent with Tilt Stroller Manual Power Assist  
Scooter Power    Type of Control:

**Manufacturer:**

**Model:**

**Serial #:**

**Size:**

**Color:**

**Age of Base:**

Current Condition of Mobility Base:

Current Condition of Mobility Base:		Age
COMPONENT	MANUFACTURER/CONDITION	
Seat platform		
Seat cushion		
Back support		
Lateral thoracic supports		
Lateral pelvic/thigh supp.		
Medial thigh/ knee supp.		
Lower leg support or strap		
Head support		
Pelvic stabilization		
Anterior chest/shoulder support		
UE support		
Tilt- post/anterior/lateral		
Recline		

Describe posture in present seating system:

Current mobility equipment does not meet medical needs. Describe limitations:

**MOBILITY SKILLS:**

Name:

RIC MR#:

Insurance/recipient #

	YES Meets needs	Does not meet mobility needs due to:										
		Risk of falling	Envir-on- mental limitations	Safety concerns & cognition	Safety concerns with physical ability	Decreased endurance & strength	Decreased Motor Skills & Coordina- tion	Pain	Pace/ Speed	Cardiac/ respiratory condition	Comments	
Use of Cane/crutches												
Use of walker												
Manual w/c propulsion: Arm : <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both Foot: <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> both												<input type="checkbox"/> Risk of repetitive strain injury <input type="checkbox"/> Upper extremity joint instability
Manual w/c w/Power Assist												
Operate scooter <input type="checkbox"/> NA												<input type="checkbox"/> Unable to transfer to scooter <input type="checkbox"/> lacks UE control for scooter <input type="checkbox"/> lacks trunk control for scooter
Operate power w/c: std. joystick <input type="checkbox"/> NA												
Operate power w/c: w/ Alternative Controls <input type="checkbox"/> NA												

**Developmental Status (Pediatrics)**

N/A

Motor development:

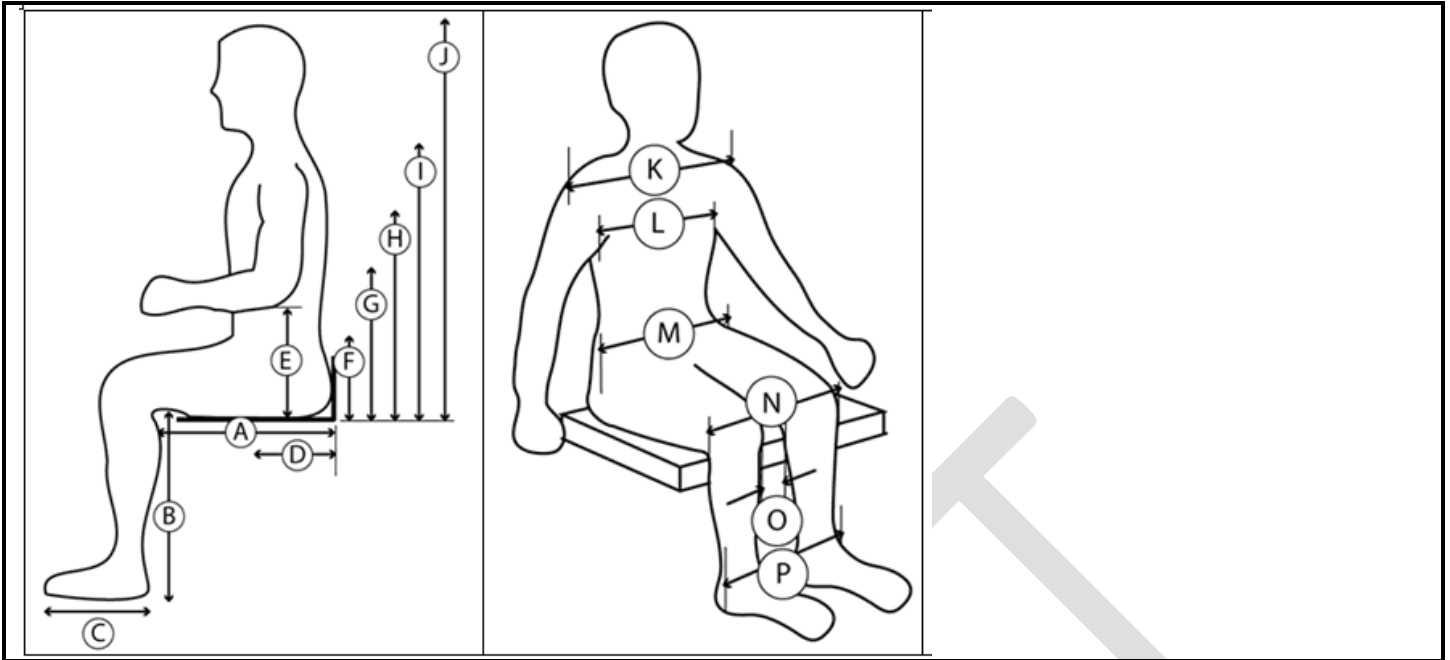
Prognosis:

Name:

RIC MR#:

Insurance/recipient #

**MAT EVALUATION:**



**Measurements in Sitting**

Left	Right		Left	Right	
		<b>A</b> Buttock/thigh depth			<b>J</b> Top of head
		<b>B</b> Lower leg length			<b>K</b> Shoulder
		<b>C</b> Foot length			<b>L</b> Chest width
		<b>D</b> Ischial depth			<b>M</b> Hip Width
		<b>E</b> Seat to elbow			<b>N</b> External Knee width
		<b>F</b> PSIS			<b>O</b> Internal knee width
		<b>G</b> Inferior scapula			<b>P</b> External ankle/foot (at widest point)
		<b>H</b> Axilla			Overall width (asymmetrical width for windswept legs or scoliotic posture)
		<b>I</b> Top shoulder			




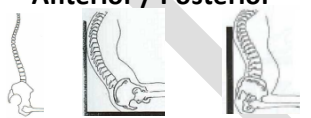


Name:

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:

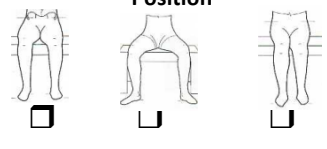

POSTURE: (MAT EVALUATION)				COMMENTS:
PELVIS	<b>Tendency:</b> <b>Anterior/Posterior</b>	<b>Obliquity</b>	<b>Rotation-Pelvis</b>	<b>Tonal Influence Pelvis:</b> <input type="checkbox"/> Paralysis <input type="checkbox"/> Flaccid <input type="checkbox"/> Low Tone <input type="checkbox"/> High Tone <input 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)	
<b>Mobility:</b> <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	<b>Anterior / Posterior</b>	<b>Lateral Flexion/Scoliosis</b>	<b>Trunk Rotation/Kyphoscoliosis</b>	<b>Tonal Influence Trunk:</b> <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 #

<b>H I P S</b>	<p style="text-align: center;"><b>Position</b></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;"><b>Windswept</b></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><b>Hip R.O.M.</b></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><b>Describe Tone/Movements LE:</b></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 <b>Describe:</b>		WFL	Left limits	Right limits	Hip Flexion				Hip Ext				Hip Abd				Hip Add																																									
	WFL	Left limits	Right limits																																																										
Hip Flexion																																																													
Hip Ext																																																													
Hip Abd																																																													
Hip Add																																																													
<b>KNEES &amp; FEET</b>	<p><b>Knee R.O.M.</b></p> <p>Left                      Right</p> <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Limitations <input type="checkbox"/> Limitations	<p><b>Foot Positioning</b></p> <input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R <b>ROM concerns:</b> 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><b>Describe Tone/Movement of head and Neck:</b></p>																																																										
<b>HEAD &amp; NECK</b>	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated L <input type="checkbox"/> Lat Flexed L <input type="checkbox"/> Rotated R <input type="checkbox"/> Lat Flexed R <input type="checkbox"/> Cervical Hyperextension	<input type="checkbox"/> Good Head Control <input type="checkbox"/> Adequate Head Control <input type="checkbox"/> Limited Head Control  <input type="checkbox"/> Absent Head Control	<p><b>Describe Tone/Movement of Shoulder/Elbow UE:</b></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"/> Other  <input type="checkbox"/> Edema UE <b>Describe:</b>																																																										
<b>SHOULDER ELBOW</b>	<p><b>Shoulders</b></p> <p>Tendency Towards:</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <b>Left</b>  <input type="checkbox"/> Functional  <input type="checkbox"/> Elevation  <input type="checkbox"/> Depression  <input type="checkbox"/> Protraction  <input type="checkbox"/> Retraction  <input type="checkbox"/> Int rotation  <input type="checkbox"/> Ext rotation  <input type="checkbox"/> Subluxed           </td> <td style="width:50%; vertical-align: top;"> <b>Right</b>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> </td> </tr> </table>	<b>Left</b> <input type="checkbox"/> Functional <input type="checkbox"/> Elevation <input type="checkbox"/> Depression <input type="checkbox"/> Protraction <input type="checkbox"/> Retraction <input type="checkbox"/> Int rotation <input type="checkbox"/> Ext rotation <input type="checkbox"/> Subluxed	<b>Right</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">R.O.M. for Shoulder/Elbow:</th> </tr> <tr> <th></th> <th>WFL</th> <th colspan="2">Limits</th> </tr> <tr> <th></th> <th></th> <th>L</th> <th>R</th> </tr> </thead> <tbody> <tr> <td>Shoulder Flex</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Shr ABD</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Shr ADD</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Elbow Flex/Ext</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">Strength for Shoulder/Elbow:</th> </tr> <tr> <th></th> <th>WFL</th> <th colspan="2">Limits</th> </tr> <tr> <th></th> <th></th> <th>L</th> <th>R</th> </tr> </thead> <tbody> <tr> <td>Shoulder Flex</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Shr ABD</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Shr ADD</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Elbow Flex/Ext</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Grades if necessary ____/5</p>	R.O.M. for Shoulder/Elbow:					WFL	Limits				L	R	Shoulder Flex				Shr ABD				Shr ADD				Elbow Flex/Ext				Strength for Shoulder/Elbow:					WFL	Limits				L	R	Shoulder Flex				Shr ABD				Shr ADD				Elbow Flex/Ext				
<b>Left</b> <input type="checkbox"/> Functional <input type="checkbox"/> Elevation <input type="checkbox"/> Depression <input type="checkbox"/> Protraction <input type="checkbox"/> Retraction <input type="checkbox"/> Int rotation <input type="checkbox"/> Ext rotation <input type="checkbox"/> Subluxed	<b>Right</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>																																																												
R.O.M. for Shoulder/Elbow:																																																													
	WFL	Limits																																																											
		L	R																																																										
Shoulder Flex																																																													
Shr ABD																																																													
Shr ADD																																																													
Elbow Flex/Ext																																																													
Strength for Shoulder/Elbow:																																																													
	WFL	Limits																																																											
		L	R																																																										
Shoulder Flex																																																													
Shr ABD																																																													
Shr ADD																																																													
Elbow Flex/Ext																																																													

Name:

RIC MR#:

Insurance/recipient #

<b>WRIST &amp; HAND</b>	<input type="checkbox"/> WNL			<b>Handedness:</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not developed due to age <input type="checkbox"/> Development not anticipated
	<b>Limitations</b>	<b>L</b>	<b>R</b>	
	<b>Contractures</b>			
	<b>Fisting</b>			
	<b>Tremors</b>			
	<b>Weak grasp</b>			
	<b>Poor dexterity</b>			
	<b>No hand function</b>			
	<b>Paralysis</b>			

**Equipment trials (DESCRIBE DURATION AND RESULTS OF TRIAL):**

Patient demonstrated ability to use equipment safely and efficiently Yes \_\_\_ No \_\_\_ Comments:

State why other equipment was not appropriate/ successful:

**Treatment Plan:**

The patient and/or caregiver actively participate in appointment for fitting and training with recommended equipment.  
 The patient and/or caregiver will demonstrate adequate knowledge of safe and functional operation of the recommended equipment  
 The patient and/or caregiver will demonstrate adequate knowledge on use and care of the recommended equipment

**Goals for Wheelchair Mobility for Client:**

Promote independence in mobility in the home  
 Promote participation with MRADLs  
 Provide dependent mobility  
 Promote independence with pressure relief  
 Provide wheelchair base that includes **tilt** to facilitate pressure relief, postural control, physiological function  
 Provide wheelchair base that includes **recline** to facilitate pressure relief, postural control, self care

**Goals for Seating system for Client:**

Optimize pressure distribution to assist in the prevention of decubitus ulcers  
 Provide support needed to facilitate safety  
 Provide corrective forces to assist with maintaining or improving posture  
 Accommodate and support client's posture: current seated postures and positions are not flexible or will not tolerate corrective forces  
 Enhance physiological function such as breathing, swallowing, digestion  
 Enhance ability to participate in ADLs

Name:

RIC MR#:

Insurance/recipient #

**MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION**

MOBILITY BASES	JUSTIFICATION	
<b>Manufacturer:</b> <b>Model:</b> <b>Color:</b> Seat width: _____ Seat depth: _____ Back hgt _____ Seat to back hgt _____ Can be grown to: width _____ depth _____	<input type="checkbox"/> provide dependent mobility <input type="checkbox"/> provide indep mobility <input type="checkbox"/> is not a safe, functional ambulator <input type="checkbox"/> walker or cane inadequate	<input type="checkbox"/> non-standard width/depth necessary to accommodate anatomical measurement <input type="checkbox"/> Equipment is a lifetime medical need
<input type="checkbox"/> <b>Manual mobility base</b>  <input type="checkbox"/> <b>Dependent base</b>	<input type="checkbox"/> Non functional ambulator <input type="checkbox"/> Able to self propel in residence <input type="checkbox"/> Unable to self propel in residence	
<input type="checkbox"/> <b>Standard manual wheelchiar</b>	<input type="checkbox"/> Self propels wheelchair <input type="checkbox"/> Propels with Assistance <input type="checkbox"/> Passive propulsion	
<input type="checkbox"/> <b>Lightweight manual wheelchair</b>	<input type="checkbox"/> Medical condition and weight of wheelchair affect ability to self propel standard manual wheelchair <input type="checkbox"/> Marginal propulsion skills	
<input type="checkbox"/> <b>High strength lightweight manual wheelchair</b>	<input type="checkbox"/> Medical condition and weight of wheelchair affect ability to self propel while engaging in frequent MRADLs that cannot be performed in a standard or lightweight manual wheelchair <input type="checkbox"/> Requires a specific seat width, depth, or height <input type="checkbox"/> Prevent repetitive use injuries	
<input type="checkbox"/> <b>Ultra lightweight multi-adjustable manual wheelchair</b>	<input type="checkbox"/> Medical condition and weight of wheelchair affect ability to self propel while engaging in frequent MRADLs that cannot be performed in a standard, lightweight, or ultra lightweight multi-adjustable manual wheelchair <input type="checkbox"/> Prevent repetitive use injuries <input type="checkbox"/> Axle requires movement in order for proper placement for independent self propulsion <input type="checkbox"/> Wheelchair back angle requires adjustablility to accommodate seat to back angle	
<input type="checkbox"/> <b>Heavy duty mobility base</b>	<input type="checkbox"/> user weight exceeds capacity <input type="checkbox"/> extreme tone	<input type="checkbox"/> broken frame/ hx of repeated repairs <input type="checkbox"/> multiple seat functions <input type="checkbox"/> over active movement
<input type="checkbox"/> <b>Stroller base</b>	<input type="checkbox"/> infant/child <input type="checkbox"/> unable to propel manual wheelchair <input type="checkbox"/> developmentally unable to propel <input type="checkbox"/> allows for growth	<input type="checkbox"/> non-functional ambulator <input type="checkbox"/> non-functional UE <input type="checkbox"/> Indep mobility is not a goal at this time
<input type="checkbox"/> <b>Power Assist</b>	<input type="checkbox"/> shoulder pain is 7/10 during manual propulsion <input type="checkbox"/> less expensive option to power wheelchair <input type="checkbox"/> repetitive strain injury present in shoulder girdle	<input type="checkbox"/> Requires conservation of enrgy to particiapte in MRADLs <input type="checkbox"/> Unable to propel up ramps or curbs using manual wheelchair
<input type="checkbox"/> <b>Scooter/POV</b>	<input type="checkbox"/> can safely operate <input type="checkbox"/> can safely transfer	<input type="checkbox"/> has adequate trunk stability <input type="checkbox"/> can not functionally propel manual wheelchair

Name:

RIC MR#:

Insurance/recipient #

<input type="checkbox"/> <b>Power mobility base</b>	<input type="checkbox"/> non-ambulatory <input type="checkbox"/> can not functionally propel manual wheelchair <input type="checkbox"/> home is accessible	<input type="checkbox"/> can not functionally and safely operate scooter/POV <input type="checkbox"/> can safely operate <input type="checkbox"/> willing to use equipment
Why mobility base was selected		
Why a lower level mobility base would not be appropriate		
<b>SEAT FUNCTION/POSITION CHANGES</b>		
<b>Tilt</b> <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Lateral <input type="checkbox"/> Power tilt on power chair <input type="checkbox"/> Power tilt on manual chair <input type="checkbox"/> Manual tilt on manual base	<input type="checkbox"/> change position against gravitational force on head and shoulders <input type="checkbox"/> change position for pressure relief/can not weight shift <input type="checkbox"/> decrease pain <input type="checkbox"/> blood pressure management	<input type="checkbox"/> management of tone <input type="checkbox"/> rest periods <input type="checkbox"/> control edema <input type="checkbox"/> facilitate postural control <input type="checkbox"/> transfers <input type="checkbox"/> control autonomic dysreflexia <input type="checkbox"/> increase sitting tolerance <input type="checkbox"/> decrease respiratory distress
<b>Recline</b> <input type="checkbox"/> Power recline on power base <input type="checkbox"/> Manual recline on manual base	<input type="checkbox"/> accommodate femur to back angle <input type="checkbox"/> bring to full recline for ADL care <input type="checkbox"/> change position for pressure relief/can not weight shift <input type="checkbox"/> decrease pain <input type="checkbox"/> blood pressure management	<input type="checkbox"/> rest periods and sleeping in chair <input type="checkbox"/> repositioning for transfers <input type="checkbox"/> head positioning <input type="checkbox"/> control autonomic dysreflexia <input type="checkbox"/> increase sitting tolerance <input type="checkbox"/> decrease respiratory distress
<b>Elevator on mobility base</b> <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter	<input type="checkbox"/> increase indep in transfers <input type="checkbox"/> increase indep in ADLs for reach	<input type="checkbox"/> raise height for eye contact which reduces cervical neck strain and pain
<input type="checkbox"/> <b>Stand or Vertical Position System</b>	<input type="checkbox"/> independent weight bearing <input type="checkbox"/> decrease joint contractures <input type="checkbox"/> pressure distribution away from scapule, sacrum, coccyx, and ischial tuberosities <input type="checkbox"/> increase digestion and elimination	<input type="checkbox"/> access to counters, cabinets <input type="checkbox"/> increase reach <input type="checkbox"/> increase interaction with others at eye level, reduces neck strain <input type="checkbox"/> increase performance of MRADLs
<b>FRAME OPTIONS</b>		
<b>Rear canes</b> <input type="checkbox"/> extended <input type="checkbox"/> angle adjustable <input type="checkbox"/> standard	<input type="checkbox"/> caregiver access <input type="checkbox"/> caregiver assist	<input type="checkbox"/> allows "hooking" to enable increased ability to perform ADLs or maintain balance
<input type="checkbox"/> <b>Seat to floor height:</b> _____	<input type="checkbox"/> foot propulsion <input type="checkbox"/> transfers <input type="checkbox"/> accommodation of leg length	<input type="checkbox"/> access to table or desk top
<b>Rear wheel axle placement/ adjustability</b> <input type="checkbox"/> None <input type="checkbox"/> semi adjustable <input type="checkbox"/> fully adjustable	<input type="checkbox"/> improved UE access to wheels <input type="checkbox"/> improved postural stability by changing angle in space	<input type="checkbox"/> 1-arm drive access <input type="checkbox"/> amputee placement <input type="checkbox"/>
<input type="checkbox"/> <b>Angle Adjustable Back</b>	<input type="checkbox"/> postural control <input type="checkbox"/> control of tone/spasticity <input type="checkbox"/> accommodation of range of motion	<input type="checkbox"/> UE functional control <input type="checkbox"/> accommodation for seating system <input type="checkbox"/>
<b>Hangers/ Leg rests</b> <input type="checkbox"/> 60 <input type="checkbox"/> 70 <input type="checkbox"/> 90 <input type="checkbox"/> center mount <input type="checkbox"/> elevating <input type="checkbox"/> heavy duty <input type="checkbox"/> articulating	<input type="checkbox"/> provide LE support <input type="checkbox"/> accommodate to hamstring tightness	<input type="checkbox"/> durability <input type="checkbox"/> enable transfers <input type="checkbox"/> decrease edema

Name:

RIC MR#:

Insurance/recipient #

<input type="checkbox"/> fixed <input type="checkbox"/> lift off <input type="checkbox"/> swing away <input type="checkbox"/> rotational hanger brackets <input type="checkbox"/> adjustable knee angle <input type="checkbox"/> calf panel <input type="checkbox"/> Longer extension tube	<input type="checkbox"/> elevate legs during recline <input type="checkbox"/> provide change in position for LE's <input type="checkbox"/> maintain placement of feet on footplate	<input type="checkbox"/> accommodate lower leg length <input type="checkbox"/> improve circulation <input type="checkbox"/> increase ground clearance
<input type="checkbox"/> Power Elevating Leg rests	<input type="checkbox"/> independently elevate legs during recline <input type="checkbox"/> provide change in position for LE's <input type="checkbox"/> maintain placement of feet on footplate	<input type="checkbox"/> decrease edema <input type="checkbox"/> actuator needed to elevate legrest <input type="checkbox"/> actuator needed to articulate legrest preventing knees from flexing <input type="checkbox"/> improve circulation <input type="checkbox"/> increase ground clearance over curbs
<b>Foot support</b> <input type="checkbox"/> adjustable Footplate <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> flip up <input type="checkbox"/> depth/angle adjustable <input type="checkbox"/> one piece footplate	<input type="checkbox"/> provide foot support <input type="checkbox"/> accommodate to ankle ROM <input type="checkbox"/> allow foot to go under wheelchair base	<input type="checkbox"/> transfers <input type="checkbox"/>
<b>Armrests</b> <input type="checkbox"/> fixed <input type="checkbox"/> adjustable height <input type="checkbox"/> removable <input type="checkbox"/> flip away <input type="checkbox"/> swing away <input type="checkbox"/> reclining Pads: <input type="checkbox"/> full length <input type="checkbox"/> desk <input type="checkbox"/> tubular	<input type="checkbox"/> provide support with elbow at 90 <input type="checkbox"/> provide support for w/c tray <input type="checkbox"/> change of height/angles for variable activities	<input type="checkbox"/> remove for transfers <input type="checkbox"/> allow to come closer to table top <input type="checkbox"/> remove for access to tables <input type="checkbox"/> use for assist in transfers <input type="checkbox"/> use for pressure relief
<input type="checkbox"/> Side guards	<input type="checkbox"/> prevent clothing getting caught in wheel or becoming soiled <input type="checkbox"/> provide hip and pelvic stabilization	<input type="checkbox"/> eliminate contact between body and wheels <input type="checkbox"/> limit hand contact with wheels
<b>Wheel size:</b> <b>Wheel Style</b> <input type="checkbox"/> mag <input type="checkbox"/> spokes <input type="checkbox"/>	<input type="checkbox"/> increase access to wheel <input type="checkbox"/> allow for seating system to fit on base	<input type="checkbox"/> increase propulsion ability <input type="checkbox"/> maintenance <input type="checkbox"/> transportation tie downs
<input type="checkbox"/> Quick Release Wheels	<input type="checkbox"/> allows wheels to be removed to decrease width of w/c for storage	<input type="checkbox"/> decrease weight for lifting <input type="checkbox"/>
<b>Wheel rims/ hand rims</b> <input type="checkbox"/> metal <input type="checkbox"/> plastic coated <input type="checkbox"/> vertical projections <input type="checkbox"/> oblique projections	<input type="checkbox"/> Provide ability to propel manual wheelchair	<input type="checkbox"/> Increase self-propulsion with hand weakness/decreased grasp
<b>Tires:</b> <input type="checkbox"/> pneumatic <input type="checkbox"/> flat free inserts <input type="checkbox"/> solid	<input type="checkbox"/> decrease maintenance <input type="checkbox"/> prevent frequent flats <input type="checkbox"/> increase shock absorbency	<input type="checkbox"/> decrease pain from road shock <input type="checkbox"/> decrease spasms from road shock <input type="checkbox"/>
<b>Caster housing:</b> <b>Caster size:</b> <b>Style:</b>	<input type="checkbox"/> maneuverability <input type="checkbox"/> stability of wheelchair <input type="checkbox"/> increase shock absorbency <input type="checkbox"/> durability <input type="checkbox"/> maintenance <input type="checkbox"/> angle adjustment for posture	<input type="checkbox"/> decrease pain from road shock <input type="checkbox"/> decrease spasms from road shock <input type="checkbox"/> allow for feet to come under wheelchair base <input type="checkbox"/> allows change in seat to floor height <input type="checkbox"/>
<input type="checkbox"/> Shock absorbers	<input type="checkbox"/> decrease vibration	<input type="checkbox"/> provide smoother ride over uneven terrain
<input type="checkbox"/> Spoke Protector	<input type="checkbox"/> prevent hands from getting caught in spokes	<input type="checkbox"/>
<input type="checkbox"/> One armed device <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> enable propulsion of manual wheelchair with one arm	<input type="checkbox"/>
<input type="checkbox"/> Anti-tippers	<input type="checkbox"/> prevent wheelchair from tipping backward	<input type="checkbox"/>
<input type="checkbox"/> Transportation tie-down option	<input type="checkbox"/> to provide crash tested tie down brackets	

Name:

RIC MR#:

Insurance/recipient #

<input type="checkbox"/> <b>Amputee adapter</b>	<input type="checkbox"/> Provide support for stump/residual extremity	
<input type="checkbox"/> <b>Ventilator tray</b>	<input type="checkbox"/> stabilize ventilator on wheelchair	
<input type="checkbox"/> <b>Crutch/cane holder</b> <input type="checkbox"/> <b>O2 Cylinder holder</b> <input type="checkbox"/> <b>IV hanger</b>	<input type="checkbox"/> Stabilize accessory on wheelchair	
<b>Brake/wheel lock extension</b> <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> increase indep in applying wheel locks through increasing the lever arm	
<b>POWER WHEELCHAIR OPTIONS</b>		
<b>Controls/input device</b> <input type="checkbox"/> Proportional <input type="checkbox"/> Non-Proportional/switches <input type="checkbox"/> Electrical <input type="checkbox"/> Mechanical Manufacturer  Model  Body Parts  rLeft rRight	<input type="checkbox"/> provides access for controlling wheelchair <input type="checkbox"/> lacks motor control to operate proportional drive control <input type="checkbox"/> unable to understand proportional controls <input type="checkbox"/> limited movement/strength <input type="checkbox"/> extraneous movement	<input type="checkbox"/> other
<input type="checkbox"/> <b>Upgraded Electronics/ Expandable controller/harness</b>	<input type="checkbox"/> programming for accurate control <input type="checkbox"/> progressive disease/changing condition <input type="checkbox"/> allows input device to communicate with drive motors and gear box <input type="checkbox"/> Required for upgraded joystick control <input type="checkbox"/> Required for alternative drive controls	<input type="checkbox"/> operate power tilt / power recline through joystick control <input type="checkbox"/> harness provides necessary connectors for operation
<input type="checkbox"/> <b>Display box</b>	<input type="checkbox"/> Allows user to see which mode and drive the wheelchair is set <input type="checkbox"/> necessary for alternate controls	
<input type="checkbox"/> <b>Upgraded tracking electronics</b>	<input type="checkbox"/> increase safety when driving	<input type="checkbox"/> correct tracking when on uneven surfaces
<input type="checkbox"/> <b>Safety Reset Switches</b>	<input type="checkbox"/> Used to change modes and stop the wheelchair when driving in latch mode	<input type="checkbox"/> Stop wheelchair
<input type="checkbox"/> <b>Single or Multiple Actuator Control Module</b>	<input type="checkbox"/> Operate seat function <input type="checkbox"/> Operate shear on back	
<input type="checkbox"/> <b>Mount for switches or joystick</b>	<input type="checkbox"/> Attaches switches to w/c <input type="checkbox"/> Swing away for access or transfers	<input type="checkbox"/> midline for optimal placement <input type="checkbox"/> provides for consistent access
<input type="checkbox"/> <b>Attendant controlled joystick plus mount</b>	<input type="checkbox"/> safety <input type="checkbox"/> long distance driving <input type="checkbox"/> operation of seat functions	<input type="checkbox"/> compliance with transportation regulations <input type="checkbox"/>
<input type="checkbox"/> <b>Battery</b>	<input type="checkbox"/> power motor on wheelchair	

Name:

RIC MR#:

Insurance/recipient #

<input type="checkbox"/> Charger	<input type="checkbox"/> charge battery for wheelchair	
----------------------------------	--	--

### SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manufacturer	Model/size	Justification	
<input type="checkbox"/> Seat Cushion			<input type="checkbox"/> accommodate impaired sensation <input type="checkbox"/> decubitus ulcers present/history <input type="checkbox"/> unable to shift weight <input type="checkbox"/> prevent pelvic extension <input type="checkbox"/> low maintenance	<input type="checkbox"/> stabilize/promote alignment <input type="checkbox"/> promote hip/ femur alignment <input type="checkbox"/> accommodate obliquity <input type="checkbox"/> accommodate multiple deformity <input type="checkbox"/> increase pressure distribution
<input type="checkbox"/> Additional Pieces on Seat Cushion				
<input type="checkbox"/> Seat Wedge			<input type="checkbox"/> accommodate ROM	<input type="checkbox"/> Provide increased aggressiveness of seat shape to decrease sliding down in the seat
<input type="checkbox"/> Cover Replacement			<input type="checkbox"/> protect back or seat cushion	<input type="checkbox"/> have one to use while the other is being washed and air dried
<b>Mounting hardwre.</b> <input type="checkbox"/> lateral trunk 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 for:		<input type="checkbox"/> attach seat platform/cushion to w/c frame <input type="checkbox"/> attach back cushion to w/c frame	<input type="checkbox"/> mount headrest <input type="checkbox"/> swing medial thigh support away <input type="checkbox"/> swing lateral supports away for transfers
<input type="checkbox"/> Seat Board <input type="checkbox"/> Back Board			<input type="checkbox"/> support cushion to prevent hammocking	<input type="checkbox"/> allows attachment of cushion to mobility base
<input type="checkbox"/> Back			<input type="checkbox"/> provide lateral trunk support <input type="checkbox"/> accommodate deformity <input type="checkbox"/> accommodate or decrease tone <input type="checkbox"/> facilitate tone	<input type="checkbox"/> provide posterior trunk support <input type="checkbox"/> provide lumbar/sacral support <input type="checkbox"/> support trunk in midline <input type="checkbox"/>
<input type="checkbox"/> Additional Pieces on Back Cushion				
<input type="checkbox"/> Lateral pelvic/thigh support			<input type="checkbox"/> pelvis in neutral <input type="checkbox"/> accommodate pelvis <input type="checkbox"/> position upper legs	<input type="checkbox"/> accommodate tone <input type="checkbox"/> removable for transfers <input type="checkbox"/>
<input type="checkbox"/> Medial/ lateral Knee 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"/> position foot <input type="checkbox"/> accommodate deformity	<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"/> provide input to heel <input type="checkbox"/> protect foot
<input type="checkbox"/> Lateral trunk Supports			<input type="checkbox"/> decrease lateral trunk leaning <input type="checkbox"/> accom asymmetry	<input type="checkbox"/> safety <input type="checkbox"/> control of tone

Name:

RIC MR#:

Insurance/recipient #

<input type="checkbox"/> R <input type="checkbox"/> L			<input type="checkbox"/> contour for increased contact	<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"/> added abdominal support <input type="checkbox"/> alignment <input type="checkbox"/> assistance with shoulder control <input type="checkbox"/> decrease shoulder elevation <input type="checkbox"/>
<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"/> Neck support			<input type="checkbox"/> decrease neck rotation <input type="checkbox"/>	<input type="checkbox"/> decrease forward neck flexion
<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 positioner <input type="checkbox"/> Belt <input type="checkbox"/> SubASIS bar <input type="checkbox"/> Dual Pull			<input type="checkbox"/> stabilize tone <input type="checkbox"/> decrease falling out of chair <input type="checkbox"/> prevent excessive rotation <input type="checkbox"/>	<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			<b>Holds</b> <input type="checkbox"/> medicines <input type="checkbox"/> special food <input type="checkbox"/> orthotics <input type="checkbox"/> clothing changes	<input type="checkbox"/> diapers <input type="checkbox"/> catheter/hygiene <input type="checkbox"/> ostomy supplies <input type="checkbox"/>
Other				
Other				
Other				
Other				

### Additional Narrative Information

---



---



---



---



---



---



