LName:	
FName:	
Date:	
MR #:	
Account #:	
Birth Date:	
Gender:	
Physician:	

Wheelchair and Seating Evaluation and Justification

PATIENT INFORMATION

Start Time: **End Time:**

This evaluation form will serve as the medical justification form for the recommended equipment	
Diagnosis:	
Seating Therapist: **Primary Therapist:**	**Supplier / Company:**
Patient Phone:	**Alternate Phone:**
Name/relationship of persons accompanying patient:	
Reason for Referral:	
Patient / Caregiver Goals:	
External Funding Source: **Contact Name:**	**County:** **Phone:**

Subjective

MEDICAL HISTORY

Age:	Height:	Weight:	Explain recent changes or trends in weight
History: (per patient report)			
Relevant past and future surgeries:			
Cardio Status: Intact Impaired NA		**Respiratory Status:** Intact Impaired NA	
Comments:			

TRANSPORTATION

Car SUV Truck Mini-Van Full-size Van Public Transportation School Bus Ambulance
If van: Tie Downs Lock down device Ramp Lift **Sits in wheelchair during transport Where is w/c stored during transport?**
Self-Driver Drives while in wheelchair Drives with adaptations Does not drive
Comments:

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ENVIRONMENT

House Mobile home Asst Living LTCF Apartment		Own Rural Rent Urban
Ramp: Yes No	Stairs: Yes No	Paved Drivway Yes No
Lives Alone Lives with Others		Hours with caregiver: NA
Home is accessible to patient: Yes No List Rooms not accessible:		
School / Employment: Specific requirements pertaining to mobility		
Comments:		

ADL STATUS (in reference to wheelchair use)

	Independent	Assist	Dependent	Supine	Sitting	Standing	NA
Dressing							
Eating							
Grooming/Hygiene							
Meal Prep							
Bathing							
Bowel Management:	Continent	Incontinent	Colostomy	Ileostomy			
Bladder Management:	Continent	Incontinent	Urostomy	Cathing			
Comments/IADL Activities:							

TRANSFERS

	Independent	Needs Assist	Dependent		Sliding Board	Manual Lift	Hoyer Lift	No Equipment	N/A
Bed									
Toilet									
Shower									
Car									
Wheelchair									
Comments:									

COMMUNICATION / VISION / COGNITION / HEARING

Verbal Communication	Understandable Difficult to understand General confusion Receptive aphasia Expressive aphasia Non-communicative
	Uses an augmentative communication device Yes No Manufacturer/Model : AAC Mount needed Yes No
Vision	Glasses and/or contacts: Yes No Neglect: Yes No If yes, which side? Right Left
Cognition	Alert and Oriented Person Place Time
Hearing	Normal Impaired
Comments:	

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SENSATION / SKIN ISSUES / PAIN / EDEMA

Sensation Issues	**Hyposensate Hypersensate Intact Impaired Absent** **Where?**
Pressure Relief (PR)	**Able to perform effective PR : Yes No Method:** **If not, Why?**
Skin Issues /Skin Integrity	**Current skin issues? Yes No Red area Open area Scar tissue** **Location:** **Treatment Surgical Conventional** **Wound care physician(s):** **Hospitilized?** **Home health care?**
	History of skin issues ? Yes No When? **Location:** **Treatment Surgical Conventional** **Wound care physician(s):** **Hospitilized?** **Home health care?**
Skin Issues Risk Factors	**Prolonged sitting** **Incontinent** **Poor nutrition** **Sliding in bed** **Sliding in chair** **Absent sensation** **Smoker** **Advanced age** **Past history of tissue trauma** **Unable to effectively shift weight** **Unable to maintain weight shift for PR**
Pain	**UE's? Yes No If yes, location: Scale: /10** **LE's? Yes No If yes, location: Scale: /10** **Back? Yes No If yes, location: Scale: /10** **Pain medicine? Yes No** **Any activity that elicits pain?** **Any activity that reduces pain?**
Edema	**Location:** **Management:**
Comments:	

Wheelchair Eval

MR# Acc#

Patient Name:

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CURRENT SEATING and MOBILITY

Does patient currently own a wheelchair/ seating system? Yes No Manual Power Hours per day in the wheelchair:	
Manufacturer: Model: Serial #:	Age of chair: Provider: Funding:
Frame width: Frame depth:	Overall width: Overall length:
Cushion:	Solid back: Yes No Model:
Front seat to floor height:	Rear seat to floor height:
Power control: Joystick Right Left Alternative drive control: Power assist wheels:	Tilt Recline Elevating leg rests Seat lift Power stander
Problems with chair:	
Describe posture in present seating system:	
Does patient currently own: Cane Crutches Walker Rolling Walker Manual Wheelchair Scooter Power Wheelchair Rollator Walker	
Comments:	

Objective

STRENGTH / ROM / SPASTICITY

Key Muscles	ROM		Strength		Spasticity**		Notes:
	Left	Right	Left	Right	Left	Right	** Test in supine position = check SP box*
Shoulder Flexion							
Shoulder abduction							** ***Ashworth Scale**:*
Shoulder IR							***1**= no increase in tone*
Shoulder ER							***2**= slight increase in tone giving a catch with movement*
Elbow flexion							
Elbow extension							***3** = marked increase in tone, but limb may be passively moved*
Wrist flexion							
Wrist extension							
Hip flexion SP							***4** = considerable increase in tone with passive movement difficult*
Knee flexion SP							
Knee extension SP							
Dorsiflexion SP							***5** = unable to be passively moved*
Plantarflexion SP							
Knee ext./hip @ 90							

Comments:

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BALANCE

Static Sitting Balance	Dynamic Sitting Balance	Static Standing Balance	Dynamic Standing Balance
Independent	Independent	Independent	Independent
Needs assist	Needs assist	Needs assist	Needs assist
Dependent	Dependent	Unable	Unable
Comments:			

POSTURE

Pelvis

Anterior / Posterior Tilt	Obliquity	Rotation
Neutral Posterior Anterior	WFL R Lower L Lower	WFL R Forward L Forward
Midline Flexibility	**Midline Flexibility**	**Midline Flexibility**
Away Towards Neutral Past	Away Towards Neutral Past	Away Towards Neutral Past

Trunk

Anterior / Posterior Curve	Left-Right Scoliosis/Lean	Rotation
WFL Thoracic Kyphosis Lumbar Lordosis	WFL Convex L Convex R c-curve s-curve multiple	Neutral Right Left
Midline Flexibility	**Midline Flexibility**	**Midline Flexibility**
Away Towards Neutral Past	Away Towards Neutral Past	Away Towards Neutral Past

Lower Extremities Position	Head and Neck	Head Control
Neutral Abduct R L Adduct R L Away Towards Neutral Past	Midline Rotated L Lat Flexed L Rotated R Lat Flexed R Cervical hyper-extension Forward head	Good Limited Absent
Comments:		

MR# Acc#

Patient Name:

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MEASUREMENTS

All measurements in inches			Left	Right
Seat to top of head		**Shoulder height**		
Hip width		**Seat to inf. angle**		
Outer shoulder		**Seat to elbow**		
Chest width		**Thigh length**		
Trunk depth		**Leg length**		
Elbow to wrist		**Foot length**		
Wrist to distal 3rd		**Foot width**		
Widest point				
Comments:				

AMBULATION

Independent **Nonfunctional** **Unable**	**Assistive device:** **Orthotic device:**	
Recent Falls Yes No **If yes, how many?** **When?**	**Tinetti Score: /28** **< 19 = high risk for falls** **20-24 = moderate risk** **NA**	**Modified Dynamic Gait Index: /12** **< 10 = risk for falls** **NA**

Patient is unable to ambulate independently with a cane the distances necessary for functional, safe, and/or timely mobility in the home.

Patient is unable to ambulate independently with a walker the distances necessary for functional, safe, and/or timely mobility in the home.

Ambulation is limited due to:

decreased balance	**decreased strength**	**decreased proprioception**
decreased endurance	**apraxia**	**decreased sensation**
pain	**ataxia**	**increased muscle tone/spasticity**
other :		

Ambulation trial NA **Resting heart rate:** **Resting O2 saturation rate:** **Post ambulation heart rate:** **Post ambulation O2 saturation rate:**	**Distance ambulated:** **Time to accomplish:** **Recovery time:**

Gait description:

Comments:

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MANUAL WHEELCHAIR MOBILITY

Independent Nonfunctional Unable

Patient is unable to propel a standard weight manual wheelchair the distances necessary for functional, safe, and/or timely mobility in the home.
Patient is unable to propel a light weight manual wheelchair the distances necessary for functional, safe, and/or timely mobility in the home.
Patient is unable to propel an optimally configured ultra-light weight manual wheelchair the distances necessary for functional, safe, and/or timely mobility in the home.

Manual wheelchair mobility is limited due to:

decreased balance	decreased proprioception	complaints of upper extremity pain
decreased strength	decreased sensation	hx of carpal tunnel syndrome
decreased endurance	increased muscle tone	hx of rotator cuff problems
decreased UE ROM	apraxia	hx of shoulder impingement
decreased coordination	ataxia	pain

inability to access wheels due to increased hip width relative to chest width and or arm length
overall required manual wheelchair width is inaccessible inside of home

other:

Wheelchair trial NA	
Resting heart rate:	Distance propelled:
Resting O2 saturation rate:	Time to accomplish:
Post W/C mobility heart rate:	Recovery time:
Post W/C mobility O2 saturation:	

Propulsion technique: Bilateral UE Bilateral LE Right UE/LE Left UE/LE

Propulsion description:

POV

Patient is able to utilize a POV? Yes No NA

If no, POV use is limited due to:

living environment cannot accommodate turning radius resulting in inaccessibility inside of home

decreased UE strength resulting in difficulties in manipulating the steering column
decreased ROM of upper extremities resulting in difficulties in reaching the steering column

shoulder pain
unable to safely transfer out of the device
decreased balance in sitting

other:

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GROUP 1 & 2 POWER WHEELCHAIR

Patient is able to utilize a Group 1 & 2 Wheelchair? **Yes** **No** **NA** **If no, Group 1 & 2 Power Wheelchair use is limited due to:** **patient has a neurological disorder** **patient has power seat functions beyond a Group 1 & 2 Power Wheelchair capability** **patient requires a seating system to accommodate positioning needs** **other:**

Assessment

There is no financial relationship between myself and the equipment supplier, , **which was present for today's appointment.** **Initial**	
Need for the equipment will be for **lifetime** **Other :**	**Current chair modifiable?** **Yes** **No** **NA** **If yes, How?**
Current chair needs replacement? **Yes** **No** **NA**	**Reason for replacement:**
Pressure mapping performed? **Yes** **No** **NA** **Saved under:** **Education provided on proper pressure relief techniques?** **Yes** **No** **NA**	**Pressure map results:**
Outpatient follow – up required? **Yes** **No** **NA**	**Pictures taken?** **Yes** **No** ***If yes, include consent form***
Patient and/or caregiver in agreement with recommendations? **Yes** **No** **NA**	
Comments:	

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WHEELCHAIR MOBILITY

Equipment trial used / Comments:
Discussed pros / cons of all wheelchairs: Yes No
Comments:

Indoor tasks		Scoring System
Maneuvers Under Table		0= not tested Not tested because of task-specific restriction or because patient declined
Maneuvers through doorway		
Maneuvers next to bed		1= unable Patient is physically unable, and no Assistant can be identified for training
Maneuvers next to toilet		
Maneuvers on/off elevator		2= close spotting Patient (assistant) needs to be closely spotted (prepared to remove hand from joystick) for safety. Performs unsafely.
Maneuvers in/out of bathroom		
Maneuvers in a congested area		
Maneuvers a u-turn		3= Verbal Cueing Patient (assistant) requires consistent verbal cues to prevent unsafe performance.
Outdoor tasks		
Maneuvers up/down grassy hill		
Maneuvers across an intersection		4= Potential for Independence Patient (assistant) demonstrates sufficient skill during task to potentially be independent (following training). Performs safely.
Maneuvers curb cut-out		
Maneuvers ramp <5 degrees		
Maneuvers on sidewalk/ tight area		5= Independent Operation Patient (assistant) is able to independently complete task. Performs safely.
Curb detection		
Obstacle detection		

GOALS

Goals for Wheelchair Mobility

- Improve safety with mobility
- Provide dependent mobility
- Meet transportation needs
- Meet vocational / educational needs
- Independence with mobility in the home and/ or in the community
- Independence with MRADLs in the home and/or in the community

Goals for Seating System

- Optimize pressure distribution
- Provide independence with pressure relief
- Maintain / improve posture
- Accommodate joint limitations
- Manage LE edema from the wheelchair
- Prevent further decline of posture
- Improve independence in reaching for objects from different surface heights
- Provide support needed to facilitate function or safety
- Enhance physiological function such as breathing, swallowing, digestion
- Decrease the amount of transfers required throughout the day
- Allow for bladder management from the wheelchair
- Improve sitting tolerance

Comments:

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Plan

It is recommended that the patient is to be seen ______ more times over the next _____ months or to be DC'd sooner if goals are met or per MD recommendations. The pt.'s POC will include today's initial evaluation, pt. /family education regarding parts, manipulation, maintenance, and care of the WC and WC mobility training.

OTHER SERVICES NEEDED

NA Outpatient PT/OT   Home health PT / OT Referral to VR   Referral to IL   Referral to MD Provided information regarding vehicle modifications Other:
Referral reasons:
Therapist makes the referral: Yes No
Was contact information provided to patient/family for needed services? Yes No

RECOMMENDATIONS

WC: Color	Back Laterals
Seat to floor height (rear):	Seat to floor height (front):
Cushion/ solid seat:	Armrests:
Legrest type	Headrest:
Other:	
Comments:	

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Justification / Notes

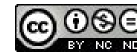
This evaluation is complete.

This evaluation is incomplete at this time. A complete evaluation will be forwarded after the next scheduled appointment.

Therapist Name Printed:		**End Time:**
Therapist's Signature		**Date:**

I have read the above plan of care, goals, and recommendations and I am in agreement:

Physician's Name Printed:		**NPI:**
Physician's Signature:		**Date:**



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