

# 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<sub>2</sub> Sat. \_\_\_\_\_ % Comments \_\_\_\_\_  
 Intact  Impaired  SOB  Hx of COPD  Hx of PE  O<sub>2</sub> PRN \_\_\_\_\_ L/Min.  O<sub>2</sub> 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  Other \_\_\_\_\_  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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grooming/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IADLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

#### 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	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Compensated	Comments _____
Motor Planning & Execution	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Compensated	Comments _____
Safety Awareness of Self/Others	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Compensated	Comments _____
Visual Processing	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Compensated	Comments _____
Behavioral Status	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> 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	<input type="checkbox"/> Intact	<input type="checkbox"/> At Risk	<input type="checkbox"/> Red Area	<input type="checkbox"/> Open Area	<input type="checkbox"/> Scar Tissue
Stage _____	Location _____	Size _____			
Stage _____	Location _____	Size _____			
Hx of Pressure Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location(s) _____	When _____		
Limited Sitting Tolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hours per Day _____			
Hx of Skin Flap Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Bony 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				Gross Range of Motion	
Upper Extremity		Lower Extremity		Shoulder	_____
<input type="checkbox"/> Normal (5/5)	<input type="checkbox"/> -	<input type="checkbox"/> Normal (5/5)	<input type="checkbox"/> -	Elbow	_____
<input type="checkbox"/> Good (4/5)	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> Good (4/5)	<input type="checkbox"/> + <input type="checkbox"/> -	Wrist	_____
<input type="checkbox"/> Fair (3/5)	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> Fair (3/5)	<input type="checkbox"/> + <input type="checkbox"/> -	Hand	_____
<input type="checkbox"/> Poor (2/5)	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> Poor (2/5)	<input type="checkbox"/> + <input type="checkbox"/> -	Hip	_____
<input type="checkbox"/> Trace (1/5)	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> Trace (1/5)	<input type="checkbox"/> + <input type="checkbox"/> -	Knee	_____
<input type="checkbox"/> No Movement	<input type="checkbox"/> + <input type="checkbox"/> -	<input type="checkbox"/> No Movement	<input type="checkbox"/> + <input type="checkbox"/> -	Ankle	_____
<input type="checkbox"/> Manual Muscle Test on file/limitations noted on pages 6 - 8				<input type="checkbox"/> Goniometric Measurements on file/limitations noted on pages 6 - 8	

Comments \_\_\_\_\_

**BALANCE**

Static Sitting	Dynamic Sitting	Static Standing	Dynamic Standing	
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> Sitting balance does not permit functional weight shift
<input type="checkbox"/> Good	<input type="checkbox"/> Good	<input type="checkbox"/> Good	<input type="checkbox"/> Good	<input type="checkbox"/> Sitting requires external support
<input type="checkbox"/> Fair	<input type="checkbox"/> Fair	<input type="checkbox"/> Fair	<input type="checkbox"/> Fair	
<input type="checkbox"/> Poor	<input type="checkbox"/> Poor	<input type="checkbox"/> Poor	<input type="checkbox"/> Poor	<input type="checkbox"/> Standing balance does not permit functional weight shift
<input type="checkbox"/> Unable / Dependent	<input type="checkbox"/> Unable / Dependent	<input type="checkbox"/> Unable / Dependent	<input type="checkbox"/> Unable / Dependent	<input type="checkbox"/> Standing requires external support
<input type="checkbox"/> Fluctuates	<input type="checkbox"/> Fluctuates	<input type="checkbox"/> Fluctuates	<input type="checkbox"/> Fluctuates	

Comments \_\_\_\_\_

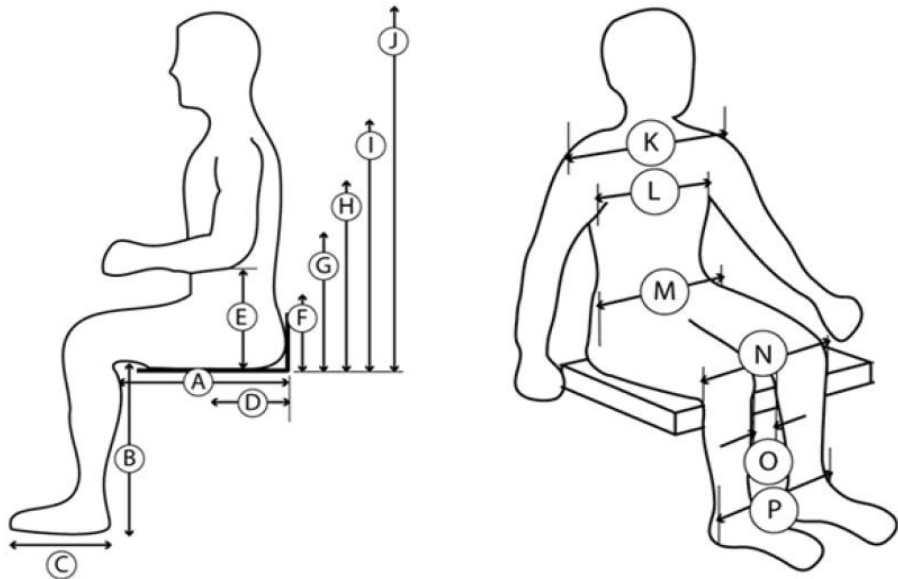
**NEURO-MOTOR**

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

Comments \_\_\_\_\_

Patient Name: \_\_\_\_\_

**MEASUREMENTS in SITTING**



Comments

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	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) <input type="checkbox"/> Physician/Clinician <input type="checkbox"/> Supplier ATP <input type="checkbox"/> 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**

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Patient Name: \_\_\_\_\_

**POSTURE IN SITTING**

	Anterior / Posterior			Obliquity (from behind)			Rotation – Pelvis			Tonal Influence – Pelvis
<b>PELVIS</b>										<input type="checkbox"/> WNL <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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Neutral	Posterior	Anterior	WFL	L Low (Obliquity)	R Low (Obliquity)	WFL	Right Anterior	Left Anterior	
	<input type="checkbox"/> Non-Reducible <input type="checkbox"/> Partially Reducible <input type="checkbox"/> Reducible - correction			<input type="checkbox"/> Non-Reducible <input type="checkbox"/> Partially Reducible <input type="checkbox"/> Reducible - correction			<input type="checkbox"/> Non-Reducible <input type="checkbox"/> Partially Reducible <input type="checkbox"/> Reducible - correction			
	<input type="checkbox"/> Self <input type="checkbox"/> External Force			<input type="checkbox"/> Self <input type="checkbox"/> External Force			<input type="checkbox"/> Self <input type="checkbox"/> External Force			
	<input type="checkbox"/> Tendency away from neutral			<input type="checkbox"/> Tendency away from neutral			<input type="checkbox"/> Tendency away from neutral			
Comments _____										

	Anterior / Posterior			Left / Right			Rotation – Shoulders/Upper Trunk	Tonal Influence – Trunk	
<b>TRUNK</b>								<input type="checkbox"/> WNL <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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	WFL	↑ Thoracic Kyphosis	↓ Thoracic Kyphosis	WFL	Convex Left	Convex Right			
	<input type="checkbox"/> Non-Reducible <input type="checkbox"/> Partially Reducible <input type="checkbox"/> Reducible - correction			<input type="checkbox"/> C-curve <input type="checkbox"/> S-curve <input type="checkbox"/> Multiple Apex Curves			<input type="checkbox"/> WFL <input type="checkbox"/> Left Anterior <input type="checkbox"/> Right Anterior		
	<input type="checkbox"/> Self <input type="checkbox"/> External Force			<input type="checkbox"/> Self <input type="checkbox"/> External Force			<input type="checkbox"/> Self <input type="checkbox"/> External Force		<input type="checkbox"/> Other
	<input type="checkbox"/> Tendency away from neutral			<input type="checkbox"/> Tendency away from neutral			<input type="checkbox"/> Tendency away from neutral		
Comments _____									

	Position			Windswept			Movement – Lower Extremities	Tonal Influence – LEs	
<b>HIPS</b>							<input type="checkbox"/> Rocks / extends at hip(s) <input type="checkbox"/> Kicks into knee extension <input type="checkbox"/> Legs push down into footrests <input type="checkbox"/> Spasms / tremors with or after movement	<input type="checkbox"/> WNL <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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other		
	Neutral	ABduct	ADduct	WFL	Right	Left			
	<input type="checkbox"/> Non-Reducible <input type="checkbox"/> Partially Reducible <input type="checkbox"/> Reducible - correction			<input type="checkbox"/> Non-Reducible <input type="checkbox"/> Partially Reducible <input type="checkbox"/> Reducible - correction					
	<input type="checkbox"/> Self <input type="checkbox"/> External Force			<input type="checkbox"/> Self <input type="checkbox"/> External Force					<input type="checkbox"/> Other
	<input type="checkbox"/> Tendency away from neutral			<input type="checkbox"/> Tendency away from neutral					
Comments _____									

**POSTURE IN SITTING**

KNEES and FEET	Knees				Feet / Ankles				Edema Scale										
	WFL	<input type="checkbox"/>	L	<input type="checkbox"/>	R	WFL	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Dorsi-Flexed	<input type="checkbox"/>	L	<input type="checkbox"/>	R	1+	Barely detectible		
Limitations	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Limitations	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Plantar Flexed	<input type="checkbox"/>	L	<input type="checkbox"/>	R	2+	Slight indentation, 15 sec. to rebound			
Non-Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Non-Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Inversion	<input type="checkbox"/>	L	<input type="checkbox"/>	R	3+	Deep Indentation, 30 sec. to rebound			
Partially Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Partially Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Eversion	<input type="checkbox"/>	L	<input type="checkbox"/>	R	4+	> 30 sec. to rebound			
Reducible - correction	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Reducible - correction	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Supination	<input type="checkbox"/>	L	<input type="checkbox"/>	R	<b>Foot Reflexes</b>				
Tendency away from neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Tendency away from neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Pronation	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Crossed Extension	<input type="checkbox"/>	L	<input type="checkbox"/>	R
Edema _____ + L _____ + R					Edema _____ + L (figure 8 measurement _____ in.) _____ + R (figure 8 measurement _____ in.)														
Comments _____																			

HEAD and NECK	Head Control				Describe Tone / Movement of the Head / Neck			
	<input type="checkbox"/> Neutral	<input type="checkbox"/>	Extended	<input type="checkbox"/>	<input type="checkbox"/> Good Head Control			
<input type="checkbox"/> Flexed	<input type="checkbox"/>	Rotated Right	<input type="checkbox"/>	<input type="checkbox"/> Fair (adequate) Head Control				
<input type="checkbox"/> Rotated Left	<input type="checkbox"/>	Absent Head Control	<input type="checkbox"/>					
<input type="checkbox"/> Lat Flexed L	<input type="checkbox"/>	Cervical Hyperextension	<input type="checkbox"/>					
<input type="checkbox"/> Non-Reducible	<input type="checkbox"/>	Reducible - correction	<input type="checkbox"/>					
<input type="checkbox"/> Partially Reducible	<input type="checkbox"/>	Self	<input type="checkbox"/>	External force				
<input type="checkbox"/> Tendency away from neutral	<input type="checkbox"/>	Asymmetric Tonic Neck Reflex	<input type="checkbox"/>	Symmetric Tonic Neck Reflex				

ARMS	Shoulders				Elbows / Forearms				Vertical Reach (in.)		Tonal influence - UEs												
	Neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Functional	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Left	Right	<input type="checkbox"/> WFL	<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			
Elevated	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Flexed	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Sitting	_____	_____											
Depressed	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Extended	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Elevated	_____	_____											
Protracted	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Pronated	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Standing	_____	_____											
Retracted	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Supinated	<input type="checkbox"/>	L	<input type="checkbox"/>	R	<b>Specific Strength / ROM Issues</b>													
Subluxed	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Non-Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R														
Rotated	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Partially Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R														
Non-Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Reducible - correction	<input type="checkbox"/>	L	<input type="checkbox"/>	R														
Partially Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Tendency a/f neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R														
Reducible - correction	<input type="checkbox"/>	L	<input type="checkbox"/>	R																			
Tendency a/f neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R																			
UE Movement / Control <input type="checkbox"/>				WNL <input type="checkbox"/>				Good / Functional <input type="checkbox"/>				Fair / Adequate <input type="checkbox"/>				Poor / Limited <input type="checkbox"/>				Absent <input type="checkbox"/>			
Comments _____																							

	Wrists				Hands / Fingers				Specific Strength / ROM Issues									
	Neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Handedness	<input type="checkbox"/>	L	<input type="checkbox"/>	R			
Flexed	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Flexed	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Grip Strength L	_____							
Extended	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Extended	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Grip Strength R	_____							
Deviated (describe)	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Deviated (describe)	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Edema L	_____							
Non-Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Non-Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Edema R	_____							
Partially Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Partially Reducible	<input type="checkbox"/>	L	<input type="checkbox"/>	R									
Reducible - correction	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Reducible - correction	<input type="checkbox"/>	L	<input type="checkbox"/>	R									
Tendency a/f neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R	Tendency a/f neutral	<input type="checkbox"/>	L	<input type="checkbox"/>	R									

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
- Contact Guard
- Min Physical Asst
- Mod Physical Asst
- Max Physical Asst
- Distance \_\_\_\_\_ ft.
- Dependent / Unable to Ambulate
- w/ device
- w/ device
- w/ device
- w/ device
- w/ device
- w/o device
- w/o device
- w/o device
- w/o device

Transfer Method

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)]

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

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

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)

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

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     Support ability to live in the community / least restrictive environment  
 Maximize independence with mobility at school, work and/or in the community     \_\_\_\_\_  
 Dependent mobility for safe transport     \_\_\_\_\_

### 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     Maximize sitting tolerance and use of wheelchair  
 Re-distribute / relieve pressure     Manage pain  
 Enhance visual orientation / line of sight     Facilitate reach biomechanics, safety, and/or range  
 Manage orthostatic hypotension and/or autonomic dysreflexia     Promote communication, engagement, arousal, and/or alertness  
 Improve transfer biomechanics, safety, and/or independence     Minimize risk for adverse occurrences, medical complications, and/or injury  
 Manage / regulate tone and/or spasticity     \_\_\_\_\_  
 Accommodate / prevent contractures and/or orthopedic deformities     \_\_\_\_\_  
 Improve circulation and/or manage edema     \_\_\_\_\_  
 Promote dynamic movement     \_\_\_\_\_

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

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

**MOBILITY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION**

POWER MOBILITY BASE	JUSTIFICATION	
<input type="checkbox"/> Not Applicable		
<input type="checkbox"/> Scooter / POV <input type="checkbox"/> 3 - wheel <input type="checkbox"/> 4 - wheel <input type="checkbox"/> _____	<input type="checkbox"/> Non-ambulatory / cannot walk <input type="checkbox"/> Not a safe, timely, and/or independent ambulator <input type="checkbox"/> Cannot functionally propel MWC <input type="checkbox"/> Conserve energy to perform/participate in ADLs <input type="checkbox"/> _____	<input type="checkbox"/> Can safely transfer to/from it <input type="checkbox"/> Has adequate balance, strength, and ROM to use <input type="checkbox"/> Willing and motivated to use <input type="checkbox"/> Home environment supports use <input type="checkbox"/> _____
<input type="checkbox"/> Basic / Standard (Group 1/2) PWC <input type="checkbox"/> Complex Rehab (Group 3) Power Wheelchair <input type="checkbox"/> Required for suspension to <ul style="list-style-type: none"> <li><input type="checkbox"/> Minimize pain</li> <li><input type="checkbox"/> Manage tone/spasticity</li> <li><input type="checkbox"/> Mitigate reflex activity</li> <li><input type="checkbox"/> Maintain balance/upright sitting</li> <li><input type="checkbox"/> Maintain posture/position/head control</li> <li><input type="checkbox"/> Maintain contact with drive control</li> <li><input type="checkbox"/> _____</li> </ul> <input type="checkbox"/> High Activity (Group 4) PWC <input type="checkbox"/> Pediatric (Group 5) PWC	<input type="checkbox"/> Non-ambulatory / cannot walk <input type="checkbox"/> Not a safe, timely, and/or independent ambulator <input type="checkbox"/> Cannot functionally propel MWC <input type="checkbox"/> Cannot functionally and/or safely operate scooter/POV <input type="checkbox"/> Home environment doesn't support use of a scooter/POV <input type="checkbox"/> Requires power seating components <input type="checkbox"/> Requires an alternative drive control <input type="checkbox"/> Willing and motivated to use <input type="checkbox"/> Home environment supports use <input type="checkbox"/> Can safely transfer/be transferred <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Requires speed adjustability <input type="checkbox"/> Requires torque adjustability <input type="checkbox"/> Requires braking adjustability <input type="checkbox"/> Requires expandable electronics <input type="checkbox"/> Requires acceleration adjustability <input type="checkbox"/> Requires sensitivity adjustability <input type="checkbox"/> _____ <input type="checkbox"/> Required to negotiate an incline of _____ ° <input type="checkbox"/> Required to negotiate obstacles/threshold of _____ " <input type="checkbox"/> Required to traverse distances/terrain <input type="checkbox"/> _____ <input type="checkbox"/> _____

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

**MOBILITY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION**

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

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

**MOBILITY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION**

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

Patient Name: \_\_\_\_\_

**MOBILITY BASE EQUIPMENT RECOMMENDATIONS & JUSTIFICATION**

MOBILITY BASE COMPONENTS		JUSTIFICATION			
<input type="checkbox"/> <b>Caster Tires</b>	<input type="checkbox"/> Solid <input type="checkbox"/> Pneumatic <input type="checkbox"/> Semi-pneumatic <input type="checkbox"/> Poly <input type="checkbox"/> Soft roll <input type="checkbox"/> Flat free inserts <input type="checkbox"/> _____	<input type="checkbox"/> Maneuverability <input type="checkbox"/> Decrease rolling resistance <input type="checkbox"/> Decrease spasms / spasticity <input type="checkbox"/> Maintenance free/prevent flats	<input type="checkbox"/> Stability of the wheelchair <input type="checkbox"/> Increase shock absorbency <input type="checkbox"/> Decrease pain <input type="checkbox"/> User unable to maintain air in tires	<input type="checkbox"/> Durability <input type="checkbox"/> _____ <input type="checkbox"/> _____	
<input type="checkbox"/> <b>Shock Absorbers / Suspension</b>		<input type="checkbox"/> Decrease spasms / spasticity <input type="checkbox"/> Increase sitting tolerance	<input type="checkbox"/> Decrease pain <input type="checkbox"/> Decrease fatigue	<input type="checkbox"/> Decrease vibration <input type="checkbox"/> _____	
<input type="checkbox"/> <b>Rear Cane / Push Handles</b>	<input type="checkbox"/> Standard <input type="checkbox"/> Extended <input type="checkbox"/> Adjustable Angle <input type="checkbox"/> Dynamic	<input type="checkbox"/> Allows "hooking" to maintain balance, perform pressure relief and / or participate in ADLs <input type="checkbox"/> Caregiver access to push w/c <input type="checkbox"/> _____	<input type="checkbox"/> Caregiver assist up/down curbs <input type="checkbox"/> _____		
<input type="checkbox"/> <b>Angle Adjustable Back</b>		<input type="checkbox"/> Postural control	<input type="checkbox"/> Accommodate available ROM	<input type="checkbox"/> Control tone / spasticity	
<input type="checkbox"/> <b>Depth Adjustable Back</b>		<input type="checkbox"/> Allow growth of system	<input type="checkbox"/> Accommodate available ROM	<input type="checkbox"/> _____	
<input type="checkbox"/> <b>Height Adjustable Back</b>		<input type="checkbox"/> Postural control	<input type="checkbox"/> Promote UE function	<input type="checkbox"/> _____	
<input type="checkbox"/> <b>Canopy</b>		<input type="checkbox"/> User has light sensitivity	<input type="checkbox"/> Regulate sensory input	<input type="checkbox"/> Protect user from the elements	
<input type="checkbox"/> <b>Cane / Crutch Holder</b> <input type="checkbox"/> <b>IV Hanger</b>		<input type="checkbox"/> User is dependent on device	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
<input type="checkbox"/> <b>O<sub>2</sub> Holder</b>		<input type="checkbox"/> User is dependent on device	<input type="checkbox"/> _____	<input type="checkbox"/> _____	
<input type="checkbox"/> <b>Ventilator Tray</b>	<input type="checkbox"/> Fixed <input type="checkbox"/> Gimbled <input type="checkbox"/> _____	<input type="checkbox"/> User is dependent on device	<input type="checkbox"/> Stabilize ventilator on wheelchair <input type="checkbox"/> _____		
<input type="checkbox"/> <b>Lights</b>		<input type="checkbox"/> Safe operation within the home once dwelling lights are turned off <input type="checkbox"/> Increase visibility at night and/or during inclement weather	<input type="checkbox"/> Increased safety while crossing street	<input type="checkbox"/> _____	
<input type="checkbox"/> <b>Essential Needs Bag / Pouch</b>	Required to hold / provide access to medically necessary	<input type="checkbox"/> Diapers / Undergarments <input type="checkbox"/> Catheter / hygiene supplies <input type="checkbox"/> Ostomy / hygiene supplies <input type="checkbox"/> Medicine <input type="checkbox"/> Special food <input type="checkbox"/> Orthotics / Prosthetics <input type="checkbox"/> Clothing for changes / weather <input type="checkbox"/> _____			

**SEATING & POSITIONING EQUIPMENT RECOMMENDATIONS & JUSTIFICATION**

COMPONENT	MFG / MODEL / SIZE	JUSTIFICATION			
<input type="checkbox"/> <b>Seat Cushion</b>		<input type="checkbox"/> Support in sitting <input type="checkbox"/> Pressure injury present <input type="checkbox"/> Stabilize pelvis in neutral <input type="checkbox"/> Accommodate post. pelvic tilt <input type="checkbox"/> Accom. multiple deformities <input type="checkbox"/> Requires protective material to move with user to maintain full contact <input type="checkbox"/> Commercially available cushion cannot accommodate deformity/shape	<input type="checkbox"/> Absent / impaired sensation <input type="checkbox"/> History of pressure injury <input type="checkbox"/> Accommodate postural asymmetry <input type="checkbox"/> Accommodate ant. Pelvic tilt <input type="checkbox"/> Support LE positioning	<input type="checkbox"/> High risk for pressure injury <input type="checkbox"/> Pressure distribution / tissue perfusion <input type="checkbox"/> Accommodate pelvic obliquity / rotation <input type="checkbox"/> _____ <input type="checkbox"/> _____	
<input type="checkbox"/> <b>Seat Pan/Solid Insert</b>	_____	<input type="checkbox"/> Accommodate seat to floor height	<input type="checkbox"/> Attach cushion to base	<input type="checkbox"/> Prevent hammocking of w/c upholstery	
<input type="checkbox"/> <b>Seat Wedge</b>	_____	<input type="checkbox"/> Accommodate ROM limitations	<input type="checkbox"/> Aggressive seat shape to minimize sliding down in / out of w/c		
<input type="checkbox"/> <b>Replacement Cover</b>	_____	<input type="checkbox"/> Protect back and/or seat cushion	<input type="checkbox"/> _____		
<input type="checkbox"/> <b>Back Cushion</b>		<input type="checkbox"/> Support in sitting <input type="checkbox"/> Support/stabilize trunk in midline <input type="checkbox"/> Accommodate postural deformity <input type="checkbox"/> Provide lumbar / sacral support <input type="checkbox"/> Accommodate / decrease tone <input type="checkbox"/> Commercially available cushion cannot accommodate deformity/shape	<input type="checkbox"/> Provide posterior support <input type="checkbox"/> Facilitate UE movement <input type="checkbox"/> Accom/reduce scoliosis lean <input type="checkbox"/> Minimize pelvic rotation <input type="checkbox"/> Facilitate tone/postural control	<input type="checkbox"/> Provide posterior and lateral support <input type="checkbox"/> _____ <input type="checkbox"/> Accom/reduce thoracic kyphosis <input type="checkbox"/> Minimize posterior pelvic tilt <input type="checkbox"/> Pressure relief over spinous processes <input type="checkbox"/> _____	
<input type="checkbox"/> <b>Back Pan / Solid Insert</b>	_____	<input type="checkbox"/> Accommodate seat depth	<input type="checkbox"/> Attach cushion to w/c back	<input type="checkbox"/> 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
<input type="checkbox"/> <b>Anterior Pelvic Support</b> ↳ <input type="checkbox"/> Pelvic belt / strap <input type="checkbox"/> Specialty pelvic support system <input type="checkbox"/> Padded <input type="checkbox"/> Other _____ <input type="checkbox"/> SubASIS bar <input type="checkbox"/> Other _____		<input type="checkbox"/> Stabilize the pelvis in neutral <input type="checkbox"/> Promote anatomical alignment <input type="checkbox"/> Maintain contact with the seat cushion <input type="checkbox"/> Mitigate posterior pelvic tilt <input type="checkbox"/> Reduce anterior pelvic tilt <input type="checkbox"/> Pelvic de-rotation / spinal alignment <input type="checkbox"/> Neutralize pelvic obliquity <input type="checkbox"/> Proximal stability for distal function <input type="checkbox"/> Protect boney prominences
<input type="checkbox"/> <b>Lateral Pelvic Support</b> ↳ <input type="checkbox"/> Right <input type="checkbox"/> Left		<input type="checkbox"/> Stabilize pelvis in neutral position <input type="checkbox"/> Accommodate tone <input type="checkbox"/> Accom. pelvic asymmetry / deformity
<input type="checkbox"/> <b>Lateral Pelvic Support Hardware</b> ↳ <input type="checkbox"/> Fixed <input type="checkbox"/> Swing-away / removable		<input type="checkbox"/> Remove / swing-away for safe transfers <input type="checkbox"/> _____
<input type="checkbox"/> <b>Lateral Thigh / Knee Support</b> ↳ <input type="checkbox"/> Right <input type="checkbox"/> Left		<input type="checkbox"/> Position thighs in neutral alignment <input type="checkbox"/> Accommodate tone <input type="checkbox"/> Decrease LE abduction <input type="checkbox"/> Accommodate windswept deformity
<input type="checkbox"/> <b>Lateral Thigh / Knee Support Hardware</b> ↳ <input type="checkbox"/> Fixed <input type="checkbox"/> Swing-away / removable		<input type="checkbox"/> Remove / swing-away for safe transfers <input type="checkbox"/> _____
<input type="checkbox"/> <b>Medial Thigh / Knee Support</b>		<input type="checkbox"/> Position thighs in neutral alignment <input type="checkbox"/> Accommodate tone <input type="checkbox"/> Decrease LE adduction <input type="checkbox"/> Accommodate windswept deformity
<input type="checkbox"/> <b>Medial Thigh / Knee Support Hardware</b> ↳ <input type="checkbox"/> Fixed <input type="checkbox"/> Swing-away / removable		<input type="checkbox"/> Remove / swing-away for safe transfers <input type="checkbox"/> _____
<input type="checkbox"/> <b>Residual Limb Support</b> → <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> Support residual limb <input type="checkbox"/> Position limb in neutral alignment
<input type="checkbox"/> <b>Foot Support</b> ↳ <input type="checkbox"/> Foot box    →    Both <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Shoe holder    → <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> Position foot/feet in neutral alignment <input type="checkbox"/> Accommodate deformity <input type="checkbox"/> Minimize extraneous mvmt/injury risk <input type="checkbox"/> Stabilize sitting base of support <input type="checkbox"/> Decrease tone / foot reflexes
<input type="checkbox"/> <b>Leg / Foot Straps</b> ↳ <input type="checkbox"/> Calf strap <input type="checkbox"/> Heel loop(s)    → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Ankle strap(s)    → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Toe strap(s)    → <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> Support foot / feet on foot support <input type="checkbox"/> Position foot / feet <input type="checkbox"/> Decrease extraneous movement <input type="checkbox"/> Provide input to ball of foot / feet <input type="checkbox"/> Protect foot / feet <input type="checkbox"/> Inhibit abnormal tone patterns <input type="checkbox"/> Increase postural stability <input type="checkbox"/> Provide input to heel
<input type="checkbox"/> <b>Dynamic Seating Component for Hips / Back</b>  <input type="checkbox"/> <b>Specialty Back System for Postural Control</b>		<input type="checkbox"/> Absorb forces to minimize risk for injury <input type="checkbox"/> Provide outlet for tone / spasticity <input type="checkbox"/> Provide mvmt. to decrease agitation <input type="checkbox"/> Provide sensory input <input type="checkbox"/> Support functional reach <input type="checkbox"/> Provide pelvic stability w/ trunk mobility <input type="checkbox"/> Absorb forces to maint. seated position <input type="checkbox"/> Support mvmt. / trunk ROM / control <input type="checkbox"/> Increase alertness / arousal <input type="checkbox"/> Minimize fatigue / incr. sitting tolerance <input type="checkbox"/> Diffuse force against w/c back <input type="checkbox"/> Participate in / perform ADLs
<input type="checkbox"/> <b>Lateral Thoracic Support</b> ↳ <input type="checkbox"/> Right <input type="checkbox"/> Left		<input type="checkbox"/> Decrease destructive postural tendency <input type="checkbox"/> Accommodate asymmetry / scoliosis <input type="checkbox"/> Control tone / spasticity <input type="checkbox"/> Curved for increased contact <input type="checkbox"/> Decrease trunk leaning / poor balance <input type="checkbox"/> Specific support for midline positioning <input type="checkbox"/> Provide core stability for function <input type="checkbox"/> Anterior / lateral for increased stability
<input type="checkbox"/> <b>Lateral Thoracic Support Hardware</b> ↳ <input type="checkbox"/> Fixed <input type="checkbox"/> Swing-away / removable		<input type="checkbox"/> Remove / swing-away for safe transfers <input type="checkbox"/> _____
<input type="checkbox"/> <b>Anterior Chest Support</b> ↳ <input type="checkbox"/> Anterior chest strap <input type="checkbox"/> Anterior chest harness <input type="checkbox"/> Shoulder harness <input type="checkbox"/> Shoulder retractors <input type="checkbox"/> Other _____		<input type="checkbox"/> Decrease forward movement of trunk <input type="checkbox"/> Increase trunk stability <input type="checkbox"/> Accommodate / facilitate movement <input type="checkbox"/> Assist with shoulder control <input type="checkbox"/> Decrease forward mvmt. of shoulders <input type="checkbox"/> Support anterior / posterior alignment <input type="checkbox"/> Provide core stability for function <input type="checkbox"/> Accommodate TLSO <input type="checkbox"/> Decrease shoulder elevation



Patient Name: \_\_\_\_\_

**SEATING & POSITIONING EQUIPMENT RECOMMENDATIONS & JUSTIFICATION**

COMPONENT	MFG / MODEL / SIZE	JUSTIFICATION
<input type="checkbox"/> <b>Upper Extremity Support</b> <input type="checkbox"/> Full tray <input type="checkbox"/> Joystick cutout <input type="checkbox"/> Half tray      → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Arm trough      → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Hand support      → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Elbow block      → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Wrist strap      → <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> Support midline trunk positioning <input type="checkbox"/> Decrease gravity's pull on shoulders <input type="checkbox"/> Minimize shoulder subluxation <input type="checkbox"/> Minimize extraneous mvmt. and injury <input type="checkbox"/> Maintain hand in neutral position <input type="checkbox"/> Prevent UEs from falling off armrests / UE support during tilt and/or recline <input type="checkbox"/> _____
<input type="checkbox"/> <b>Upper Extremity Support Mounting Hardware</b> <input type="checkbox"/> Fixed <input type="checkbox"/> Swing-away / removable <input type="checkbox"/> Swivel <input type="checkbox"/> Elevating-swivel		<input type="checkbox"/> Provide support for UE function <input type="checkbox"/> Proper tray placement w/o interference <input type="checkbox"/> Support flaccid UE(s) <input type="checkbox"/> Control tone / spasticity <input type="checkbox"/> _____
<input type="checkbox"/> <b>Head Support</b> <input type="checkbox"/> Posterior head pad <input type="checkbox"/> Contoured headrest <input type="checkbox"/> Posterior-lateral head support system <input type="checkbox"/> Lateral head support      → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Facial support      → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Anterior head support / strap		<input type="checkbox"/> Remove / swing-away for safe transfers <input type="checkbox"/> UE alignment at shoulder <input type="checkbox"/> Decrease edema <input type="checkbox"/> _____
<input type="checkbox"/> <b>Head / Neck Support</b> <input type="checkbox"/> Occipital support <input type="checkbox"/> Neck support <input type="checkbox"/> Occiput-lateral support      → <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Neck and anterior chest support system		<input type="checkbox"/> Provide posterior support for the head <input type="checkbox"/> Provide posterior-lateral support <input type="checkbox"/> Provide lateral head support <input type="checkbox"/> Accommodate ROM limitations <input type="checkbox"/> Improve chewing / swallowing <input type="checkbox"/> Visual / auditory access to environment <input type="checkbox"/> Head support during tilt and/or recline <input type="checkbox"/> Support midline head positioning <input type="checkbox"/> Provide anterior head support <input type="checkbox"/> Mitigate tone / neck reflex activity <input type="checkbox"/> Improve respiration <input type="checkbox"/> _____
<input type="checkbox"/> <b>Head / Neck Support Hardware</b> <input type="checkbox"/> Fixed <input type="checkbox"/> Swing-away / removable <input type="checkbox"/> Multi-axis      _____ <input type="checkbox"/> Dynamic seating component for head		<input type="checkbox"/> Decrease neck rotation <input type="checkbox"/> Mitigate tone / neck reflex activity <input type="checkbox"/> _____ <input type="checkbox"/> _____
This section was completed by (check all that apply) <input type="checkbox"/> Physician/Clinician <input type="checkbox"/> Supplier ATP <input type="checkbox"/> 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** \_\_\_\_\_