Physical/Occupational Therapy Wheelchair Evaluation

Mobility Equipment Recommendation and Justification

Therapist: _____ **Date of Evaluation:** _____

License Number: _____ **Time of Evaluation:** _____

Patient Name: _____

DOB:	Sex: ☐ M ☐ F	Height:	Weight:
Address:		Primary Phone: Secondary Phone:	Phone(s):
Mobility MD[1]:		MD Phone:	Fax:
Primary Insurance:		ID:	Group:
Secondary Insurance:		ID:	Group:
Team Goals:			

Medical History

Primary Diagnosis:	Secondary Diagnosis:	
Other Diagnoses:		
History:	Progressive Condition: ☐ Yes ☐ No Future Concerns:	
Skin Sensation: ☐ Intact ☐ Impaired ☐ Absent	List any surgeries related to dx or skin issues:	
Skin Issues[2]: ☐ Yes ☐ No	Pain Level (1-10, with 10 being worst):	
Able To Pressure Relief: ☐ Yes ☐ No	If No, please explain:	

[1] MD who is performing Face-to-face evaluation

[2] Please include history and current, if applicable

Patient Name: _____

Environment

☐ House ☐ Apartment ☐ Mobile Home ☐ Assisted Living Other:_____	Stories:
☐ Lives Alone ☐ Lives With Others:_____ Hours With Others:_____	
Ramp In Place: ☐ Yes ☐ No If No, is customer working on getting a ramp? ☐ Yes ☐ No Describe Ramp:	

Mobility/Ambulation (Current Status)

MRADL	Independent	Assist	Unable	Ind. w/ Current Equipment	Comments
Ambulation	☐	☐	☐	☐	
Dressing	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Grooming	☐	☐	☐	☐	
Meal Prep	☐	☐	☐	☐	
Instrumental	☐	☐	☐	☐	
Catheter Utilization: ☐ Y ☐ N			**Type:**		

Current Mobility Equipment[3]

Mobility Device ☐ None ☐ Cane/Crutch/Walker ☐ Manual ☐ Scooter ☐ Power ☐ Complex Power
Describe overall condition of unit:
Does the current equipment meet the client's need(s) in regards to their ability to complete their MRADLS in a safe and timely manner? ☐ Y ☐ N
If No, please explain why not:
If Yes, please explain why new equipment is needed (i.e. past 5 year useful lifetime, worn beyond repair, etc.)

Strength/Range of Motion

	Left U.E.	Right U.E.	Left L.E.	Right L.E.	Comments
Strength					
Range of Motion					

[3] If client has more than one, list the most aggressive. For instance, if a client has a walker and a manual wheelchair, list the manual wheelchair.

Patient Name: _____

Equipment Algorithm

Algorithm	Yes	No
Patient has mobility limitation that significantly impairs safe and/or timely participation in one or more MRADLS?	☐	☐
Will recommended equipment sufficiently improve ability to participate and/or be aided in participation of MRADL?	☐	☐
Does the patient or caregiver demonstrate ability and/or willingness to use the recommended equipment?	☐	☐
Does the patient's home environment support the use of the recommended equipment?	☐	☐
Can the current mobility limitation be fully resolved by only a cane or walker (walking device)? If **YES**, order walking device and do not proceed. If **NO**, proceed.	☐	☐
Does the patient have the functional ability to self-propel a configured manual wheelchair? If **YES**, order specific wheelchair. If **NO**, proceed.	☐	☐
Does the patient have sufficient strength, trunk stability and ability to transfer independently to operate a POV, also known as a scooter? ***Also, patient must NOT require any specific seat cushions or elevating leg rests as these are not available on a scooter!*** If **YES**, order scooter/POV. If **NO**, proceed.	☐	☐
Does the patient, or caregiver, have the ability to operate a power wheelchair? If **YES**, order power wheelchair. If **NO**, please specify equipment below and justification for it.	☐	☐

Equipment Recommendation(s)

- ☐ **Standing Frame**
  Justification: _____
- ☐ **Walker/Gait Trainer**
  - o **Anterior**
  - o **Posterior**
- ☐ **Manual Wheelchair (Choose only 1 base)**
  - o **Standard**
  - o **Lightweight**
  - o **High Strength Lightweight** (*must answer one below*)
    - ☐ Specific seat-to-floor height needed: _____
    - ☐ Specific seat dimensions needed: _____
  - o **Ultra Lightweight** (*must answer one below*)
    - ☐ Fully adjustable axle needed: _____
    - ☐ Other: _____
  - o **Manual Tilt-in-space** (*must answer both below*)
    - ☐ Client unable to pressure relieve independently
    - ☐ Client cannot use power mobility
- ☐ **POV/Scooter**
- ☐ **Basic Powerchair**
- ☐ **Complex Powerchair** (*Group 2 or Group 3 (requires either a neurological condition, myopathy, or congenital skeletal deformity for Group 3*))

Patient Name: _____

- ☐ **Power positioning**: ☐ **Yes** ☐ **No** (*If Yes, please check at least one below*)
  - o Patient is at high risk for pressure sore development and is unable to functionally pressure relieve independently throughout the entire day
  - o Patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed
  - o Power seating system is needed to manage tone or spasticity
- ☐ Please check appropriate **Power Seating** below, if recommended (*may select more than one*)
  - o **Power Tilt**
  - o **Power Recline**
  - o **Power Tilt/Recline**
  - o **Power Legs**
- ☐ **Alternative drive**: ☐ **Yes** ☐ **No** (*If Yes, please select below and justify*)
  - o **Head Array**
  - o **Chin Control**
  - o **Sip and Puff**
  - o **Remote Joystick, other**
  - o **Switches**
  - o **Other**: _____

  Justification for selection above: _____

  _____

  _____
- ☐ **Seating**
  - o **Off-the-shelf** seating is appropriate
  - o **Custom seating** is needed as off-the-shelf seating will not be able to meet the needs of this client
- ☐ **Manual and/or Power Wheelchair Accessories**:
  - o **Headrest**
    Justification: _____
  - o **Swing-away, Retractable, or Removeable Hardware(s)**
    Justification: _____
  - o **Adjustable Height Armrests**
    Justification: _____
  - o **Adjustable Angle Footplate(s)**
    Justification: _____
  - o **Flat-Free Tire Inserts**
    Justification: _____
  - o **Wheel Braking System(s) and Lock(s)**
    Justification: _____

Patient Name: _____

- o **Batteries**
  Justification: _____
- o **Expandable Controller**
  Justification: _____
- o **Anti-tips/Anti-Rollback**
  Justification: _____
- o **Lateral Supports (Thoracic or Pelvic)**:
  Justification: _____
- o **Other (1)**: _____
  Justification: _____
- o **Other (2)**: _____
  Justification: _____
- o **Other (3)**: _____
  Justification: _____
- o **Other (4)**: _____
  Justification: _____

Signatures

As the evaluating therapist, I hereby **attest** that I have personally completed this evaluation and that I am **not** an employee of, or working under contract, to the manufacturer(s) or the provider(s) of the equipment recommended in my evaluation. I further **attest** that I have **not** and will **not** receive remuneration of any kind form the manufacturer(s) or the provider(s) for the equipment that I have recommended in this evaluation.

Therapist Signature _____

Therapist Name (Printed) _____

Therapist Signature Date _____

I have reviewed and agree with the findings in this evaluation as to the recommended equipment and so order the equipment.

Physician's Signature _____

Physician's Name (Printed) _____

Physician's Signature Date _____