Wheeled Mobility and Seating Evaluation

PATIENT INFORMATION

Name	DOB	Sex	Date	Time

Address	Medical Record #	D/C Date
	Therapist	The following supplier/**ATP** was present and participated in this evaluation and recommendation.
	Therapist seating CRT experience and credentials	
Phone	Physician	_____
Spouse/Parent/Caregiver Name	1º Insurance/Payor Policy #	Supplier Company
Phone	2º Insurance/Payor Policy #	Phone

Reason for Referral	☐ Current w/c no longer meets needs ☐ Current w/c beyond repair ☐ Non-ambulatory ☐ Ambulation not independent, safe or timely	☐
Patient Goals		
Caregiver Goals		
Specific Mobility Limitations that May Affect Care	☐ ☐ See FMA in Medical Record	

MEDICAL HISTORY

Diagnosis	ICD10 Code	**1º Dx Onset**	ICD10 Code	Diagnosis	
	ICD10 Code	Diagnosis	ICD10 Code	Diagnosis	
Progressive Disease ☐	**Relevant Past and/or Future Surgeries** ☐ Bone ☐ Skin ☐ Muscle ☐ Joint ☐ _____				
Height	**Weight**	Explain recent changes or trends in weight			

Pertinent Medical History

Autonomic System ☐ Intact ☐ Impaired ☐ Hx of Autonomic Dysreflexia ☐ Hx of Thermoregulatory Dysfunction ☐

Comments

Cardiac Status RestingHR/Pulse Resting BP _____ | Functional Limitations

☐ Intact ☐ Impaired ☐ Severely Impaired ☐ Pace Maker ☐ Cardiac Precautions ☐ Hx of MI ☐ Hx of A-fib
☐ Hx of Tachycardia / Bradycardia ☐ Hx of Orthostatic Hypotension ☐ Syncope ☐ _____

Comments

Respiratory Status Resting Resp. Rate _____ Resting O_2 Sat. _____ | Functional Limitations

☐ Intact ☐ Impaired ☐ SOB ☐ O_2 PRN _____ L / Min. ☐ O_2 Dep _____ L / Min. ☐ Ventilator Dep
☐ Hx of Chronic Congestion ☐ _____

Comments

Medications that may affect mobility/positioning
☐ See medication list in Medical Record

Prosthetics, Orthotics and/or Splints Used

CURRENT MOBILITY ASSISTIVE EQUIPMENT (MAE) / SEATING

Current Mobility Device ☐ None ☐ Cane ☐ Walker ☐ Stroller ☐ Manual w/c ☐ Manual w/ tilt ☐ Manual w/ recline
☐ Scooter ☐ Power w/c ☐ Power w/ tilt ☐ Power w/ recline ☐ Power w/ tilt & recline ☐ w/ seat elevator ☐ w/ stand

Manufacturer Model Type of control

Serial # Color Age of Mobility Base

Additional Components

Seat Height Seat Width Seat Depth

Condition of Current Mobility Device

Problems with Current Mobility Device

Current Seating System

COMPONENT	MANUFACTURER / CONDITION / PROBLEMS	Age of Seating Components
Seat Base		
Mounting Hardware		
Cushion		
Pelvic Support		
Lateral Thigh/Knee Support		
Medial Knee Support		
Foot Support		
Foot Strap / Heel Loop		
Back		
Mounting Hardware		
Lateral Trunk Supports		
Chest / Shoulder Support		
Head Support		
Mounting Hardware		
UE Support		
Mounting Hardware		
Other		
Other		

When Relevant	Overall W/C Length	Overall W/C Width	Overall W/C Height

☐ This section was completed by Physician/Clinician evaluating patient

☐ This section was completed by supplier ATP present at the evaluation

☐ This section was completed by supplier ATP on a separate document

Is the current mobility device meeting the patient's physical, functional, environmental and medical needs?

☐ Yes ☐ No

Comments

HOME ENVIRONMENT

Setting: ☐ Rural ☐ Urban ☐ Suburban ☐ Paved Roads ☐ Sidewalks ☐ Rough Terrain ☐ Other

☐ House ☐ Condo/Town Home ☐ Apartment ☐ Asst Living ☐ LTCF ☐ Other ☐ Own ☐ Rent

☐ Lives Alone / No Caregivers ☐ Lives Alone / Caregiver Asst ☐ Lives with Caregiver(s) **Hours Home Alone**

Comments

Ability to safely reach (in sitting) ☐ Dresser Drawers ☐ Closet Rod ☐ Medicine Cabinet ☐ BR Faucet/Shower
☐ Freezer/Refrigerator ☐ Oven/Stove ☐ Microwave ☐ Kitchen Sink ☐ Cupboards/Drawers/Shelves
☐ Light Switches ☐ Thermostat ☐ Phone ☐ Fire Alarm ☐ Door Eye Hole/Viewer ☐ Elevator Buttons
☐ **Uses powered adj. height seat to do above reaching** **Comments**

Home is Accessible to Wheelchair ☐ Yes ☐ No Storage of Wheelchair ☐ In Home ☐ Other
Stairs ☐ Yes ☐ No Ramp ☐ Yes ☐ No Degree of Incline _____ Thresholds ☐ Yes ☐ No Height
Surfaces ☐ Carpet (Describe) _____ Tile ☐ ☐ Wood ☐ Stone/Brick ☐ Other

Non-accessible areas in home

Modifications planned

Comments

This section completed by ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document (check all that apply)

COMMUNITY ENVIRONMENT

Employment/Volunteer
☐ N/A ☐ Specific requirements pertaining to mobility

School
☐ N/A ☐ Specific requirements pertaining to mobility

Other Community Mobility ☐Medical Appointments ☐ Religious ☐ Civic Duties ☐ Other _____
☐ IADLs
☐ N/A ☐ Specific requirements pertaining to mobility

This section completed by ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document (check all that apply)

TRANSPORTATION

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

Vehicle Adaptations ☐ None ☐ Ramp ☐ Lift ☐ Hand controls ☐ Other _____
☐ Tie Downs Type _____ ☐ Lock-down System Type _____
Method of Riding ☐ 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 (WxDxL)
If necessary, client or caregiver can load/unload equipment into vehicle ☐ Yes ☐ No

Vehicle Dimensions
Door Height _____ Inside Height _____ Door Width _____
Ramp WxL _____ Weight Capacity _____
Other

This section completed by ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document (check all that apply)

CURRENT MRADL Status (Getting to the location where the ADL is performed with present MAE)

	Indep without MAE	Indep with current MAE	Assist with current MAE	Unable/ Dep with current MAE	N/A	Comments / Equipment
Dressing	☐	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	☐	
Grooming/Hygiene	☐	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	☐	
Bathing	☐	☐	☐	☐	☐	
IADLS	☐	☐	☐	☐	☐	

Bowel Mgmt ☐ Continent ☐ Incontinent ☐ Accidents ☐ Protective Undergarments ☐ Colostomy ☐ Bowel Program
Comments

Bladder Mgmt ☐ Continent ☐ Incontinent ☐ Accidents ☐ Protective Undergarments ☐ Urinal / Bed Pan / Commode
☐ Intermittent Catheterization ☐ Indwelling Catheter ☐ External/Condom Catheter ☐ Supra-Pubic Catheter
Comments

DESCRIBE WHAT HAS CHANGED TO REQUIRE NEW AND/OR DIFFERENT MOBILITY ASSISTIVE EQUIPMENT

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 Communicator – Method
☐ Augmentative Communication Device Manufacturer/Model _____

☐ AAC Mount Needed Type _____

PROCESSING SKILLS

Visual Processing	☐ Intact ☐ Impaired ☐ Compensated	Comments
Motor Planning and Execution	☐ Intact ☐ Impaired ☐ Compensated	Comments
Safety awareness of self and others	☐ Intact ☐ Impaired ☐ Compensated	Comments
Attention to environment		
Behavioral Status		
Additional comments regarding processing skills and ability to safely use wheelchair		

PAIN, SENSATION and SKIN INTEGRITY

Sensation

☐ Intact ☐ Impaired ☐ Absent
☐ Hyposensate ☐ Hypersensate
Location(s) of impairment/absence

Comments

Pressure Relief

Able to perform effective pressure relief/reperfusion at seated surface ☐ Yes ☐ No
Method: ☐ Stand up (independently, without risk of falling)
☐ Lean side to side (without 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 seat functions to perform pressure relief ☐ Yes ☐ No
Pressure Map Results ☐ N/A ☐ on File

Skin Integrity

Current Skin Integrity
☐ Intact ☐ Red Area ☐ Open Area
Location(s) _____
Size(es) _____
☐ Scar Tissue ☐ At Risk -Prolonged Sitting

Hx of Pressure Injury ☐ Yes ☐ No
Location(s) _____
When _____
Limited Sitting Tolerance ☐ Yes ☐ No
Hours per Day

Hx of Skin/Flap Surgery ☐ Yes ☐ No
Location(s) _____
When _____
Comments

Risk Factors for Skin Braden Score, if administered _____ **(**Braden Scale is used for individuals who are bedridden-not for seated persons)
☐ Bony prominences ☐ Immobility ☐ Incontinence ☐ Impaired nutritional or hydration status ☐ Aging skin
☐ Compromised circulatory status ☐ Tendency towards moisture build up (profound perspiration, skin folds)
☐ Other

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?

STRENGTH / RANGE OF MOTION

Gross Overall Strength		**Gross Range of Motion**	
Upper Extremity	**Lower Extremity**	Shoulder	
☐ Normal 5 / 5 ☐ -	☐ Normal 5 / 5 ☐ -	Elbow	
☐ Good 4 / 5 ☐ + ☐ -	☐ Good 4 / 5 ☐ + ☐ -	Wrist	
☐ Fair 3 / 5 ☐ + ☐ -	☐ Fair 3 / 5 ☐ + ☐ -	Hand	
☐ Poor 2 / 5 ☐ + ☐ -	☐ Poor 2 / 5 ☐ + ☐ -	Hip	
☐ Trace 1/ 5 ☐ + ☐ -	☐ Trace 1/ 5 ☐ + ☐ -	Knee	
☐ No Movement	☐ No Movement	Ankle	
☐ Manual Muscle Test on file/limitations noted on pgs 6/7		☐ Goniometric Measurements on file/limitations noted on pgs 6/7	
Comments			

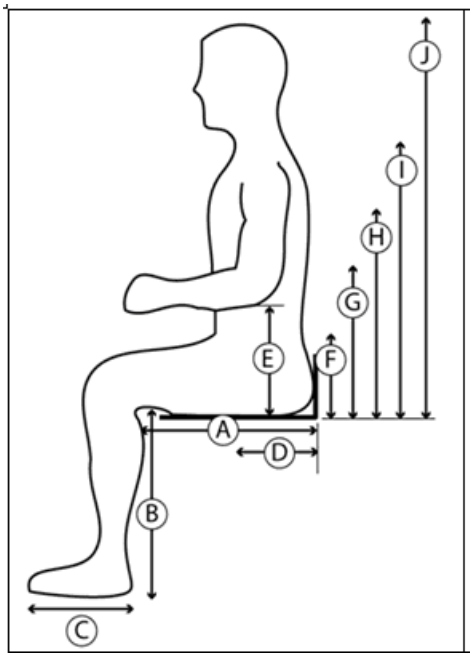
BALANCE

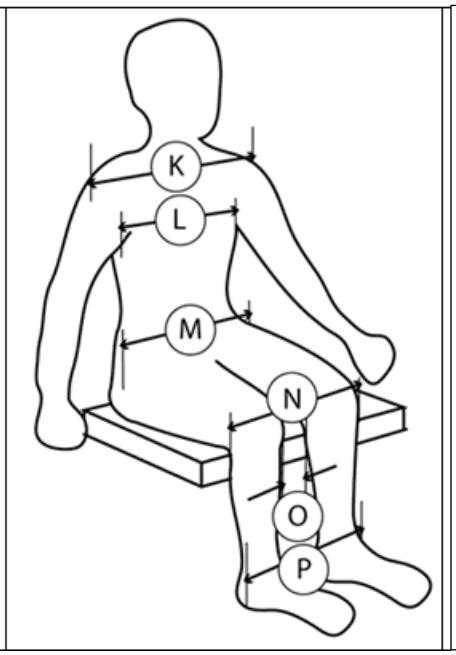
Static Sitting	**Dynamic Sitting**	**Static Standing**	**Dynamic Standing**
☐ Independent	☐ Independent	☐ Independent	☐ Independent
☐ Min assist	☐ Min assist	☐ Min assist	☐ Min assist
☐ Mod assist	☐ Mod assist	☐ Mod assist	☐ Mod assist
☐ Max assist	☐ Max assist	☐ Max assist	☐ Max assist
☐ Uses UE	☐ Uses UE	☐ Uses UE	☐ Uses UE
☐ Unable / Dependent	☐ Unable / Dependent	☐ Unable / Dependent	☐ Unable / Dependent
Comments			

NEURO-MOTOR

☐ WNL ☐ Spasticity / Hypertonicity ☐ Flaccidity / Hypotonicity ☐ Fluctuating Tone ☐ Ataxia ☐ Athetoid Movements ☐ Dystonia **Comments**	☐ Primitive Reflexes ☐ Tremors ☐ Muscle Spasms / Clonus ☐ Paralysis ☐	MODIFIED ASHWORTH SCORE (0, 1, 1+, 2, 3, 4) ☐ Muscle(s) Tested ☐ On file ☐ noted on pgs 6/7 | Score | | | | | | | | | | | |

MEASUREMENTS in SITTING





Comments

Left	Right					
		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 (at widest point)
		H	Axilla height			
		I	Shoulder height (top)			
		+	Overall width (asymmetrical width for windswept legs, scoliotic posture or other postural asymmetry		**+**	Overall depth (leg length discrepancy, accommodate adipose tissue or other posture

This section completed by ☐ Physician/Clinician ☐ Supplier ATP ☐ Supplier ATP on a separate document (check all that apply)

Orientation of Seat to Back and Seat to Thigh Supports			
Accommodate	☐ Left ☐ Right ☐ Both sides	☐ Left ☐ Right ☐ Both sides	**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°	

POSTURE in SITTING

PELVIS

Anterior / Posterior

☐ Neutral ☐ Posterior ☐ Anterior

☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Self ☐ External Force
☐ Tendency away from neutral

Obliquity (viewed from behind)

☐ WFL ☐ L low (Obliquity) ☐ R low (Obliquity)

☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Self ☐ External Force
☐ Tendency away from neutral

Rotation - Pelvis

☐ WFL ☐ Right Anterior ☐ Left Anterior

☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Self ☐ External Force
☐ Tendency away from neutral

Comments

COMMENTS

Tonal Influence Pelvis:

☐ Normal
☐ Paralysis
☐ Flaccid
☐ Low tone
☐ High tone
☐ Spasticity
☐ Dystonia
☐ Pelvic thrust
☐ Other:

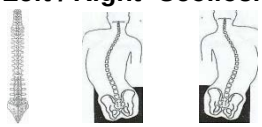
TRUNK

Anterior / Posterior

☐ WFL ☐ ↑ Thoracic Kyphosis ☐ ↓ Thoracic Kyphosis
☐ ↓ Lumbar Lordosis ☐ ↑ Lumbar Lordosis

☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Self ☐ External Force
☐ Tendency away from neutral

Left / Right -Scoliosis



☐ WFL ☐ Convex Left ☐ Convex Right
☐ C-curve ☐ S-curve
☐ Multiple Apex curve(s)

☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Self ☐ External Force
☐ Tendency away from neutral

Rotation – Shoulders and Upper Trunk

☐ Neutral
☐ Left-anterior
☐ Right-anterior

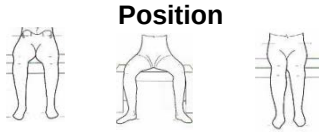
☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Self ☐ External Force
☐ Tendency away from neutral

Tonal Influence Trunk:

☐ Normal
☐ Paralysis
☐ Flaccid
☐ Low tone
☐ High tone
☐ Spasticity
☐ Dystonia
☐ Pelvic thrust
☐ Other

HIPS

Position



☐ Neutral ☐ ABduct ☐ ADduct

☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Tendency away from neutral
☐ Dislocated ☐ Subluxed

Windswept

☐ Neutral ☐ Right ☐ Left

☐ Non-Reducible (Fixed)
☐ Partly Reducible
☐ Reducible (Flexible)
☐ Self ☐ External Force
☐ Tendency away from neutral

Tone/Movements LE

☐ Normal
☐ Paralysis
☐ Flaccid
☐ Low tone
☐ High tone
☐ Spasticity
☐ Dystonia

☐ Rocks/extends at hip
☐ Kicks into knee extension
☐ Pushes legs downward into footrests
☐ Spasms/tremors with or after movement
☐

KNEES & FEET

KNEES

WFL	☐ L ☐ R
Limitations	☐ L ☐ R
Non-Reducible (Fixed)	☐ L ☐ R
Partly Reducible	☐ L ☐ R
Reducible (Flexible)	☐ L ☐ R
Tendency away from neutral	☐ L ☐ R

Edema _____+ L _____+ R

FEET/ANKLES

WFL	☐ L ☐ R		
Limitations	☐ L ☐ R	Dorsi-Flexed	☐ L ☐ R
Non-Reducible (Fixed)	☐ L ☐ R	Plantar Flexed	☐ L ☐ R
Partly Reducible	☐ L ☐ R	Inversion	☐ L ☐ R
Reducible (Flexible)	☐ L ☐ R	Eversion	☐ L ☐ R
Tendency away from neutral	☐ L ☐ R		

Edema _____+ L (fig. 8 _____in.) / _____+ R (fig. 8 _____in.)

EDEMA SCALE

1+ (barely detectible)
2+ (slight indentation, 15 sec. to rebound)
3+ (deeper indentation, 30 sec. to rebound)
4+ (> 30 sec. to rebound)

HEAD & NECK	☐ Functional ☐ Flexed ☐ Extended ☐ Rotated L ☐ Rotated R ☐ Lat Flexed L ☐ Lat Flexed R ☐ Non-Reducible (Fixed) ☐ Partially Reducible ☐ Reducible (Flexible) ☐ Tendency away from neutral ☐ Self ☐ External force	☐ Good Head Control ☐ Adequate Head Control ☐ Limited Head Control ☐ Absent Head Control ☐ Cervical Hyperextension	**Describe Tone/Movement of Head and Neck**

ARMS	**SHOULDERS**	**ELBOWS / FOREARMS**	**Functional Reach (in.)**		**Tonal Influence Upper Extremities UEs:**
			Right	**Left**	
	Functional ☐ L ☐ R	Functional ☐ L ☐ R	Sitting		☐ Paralysis
	Elevated ☐ L ☐ R	Flexed ☐ L ☐ R	Elevated		☐ Flaccid
	Depressed ☐ L ☐ R	Extended ☐ L ☐ R	Standing		☐ Low tone
	Protracted ☐ L ☐ R	Pronated ☐ L ☐ R			☐ High tone
	Retracted ☐ L ☐ R	Supinated ☐ L ☐ R			☐ Spasticity
	Subluxed ☐ L ☐ R	☐ L ☐ R			☐ Dystonia
	Rotated ☐ L ☐ R	☐ L ☐ R			☐ Other
	Non-Reducible (Fixed) ☐ L ☐ R	Non-Reducible (Fixed) ☐ L ☐ R	☐ Good UE mvmt/control		**Specific Strength/ROM Issues:**
	Partially Reducible ☐ L ☐ R	Partially Reducible ☐ L ☐ R	☐ Functional UE mvmt/control		
	Reducible (Flexible) ☐ L ☐ R	Reducible (Flexible) ☐ L ☐ R	☐ Limited UE mvmt/control		
	Tendency away from neutral ☐ L ☐ R	Tendency away from neutral ☐ L ☐ R	☐ Absent UE mvmt/control		

WRISTS HANDS	**WRISTS**	**HANDS / FINGERS**	
	Functional ☐ L ☐ R	Functional ☐ L ☐ R	Handedness ☐ L ☐ R
	Flexed ☐ L ☐ R	Flexed ☐ L ☐ R	
	Extended ☐ L ☐ R	Extended ☐ L ☐ R	Grip strength L _____#
	Deviated (describe) ☐ L ☐ R	Deviated (describe) ☐ L ☐ R	Grip strength R _____#
	Non-Reducible (Fixed) ☐ L ☐ R	Non-Reducible (Fixed) ☐ L ☐ R	
	Partially Reducible ☐ L ☐ R	Partially Reducible ☐ L ☐ R	Edema L _____+
	Reducible (Flexible) ☐ L ☐ R	Reducible (Flexible) ☐ L ☐ R	Edema R _____+
	Tendency away from neutral ☐ L ☐ R	Tendency away from neutral ☐ L ☐ R	

MOBILITY EVALUATION

TRANSFERS and AMBULATION

Transfers	**Ambulation**			
☐ Independent	☐ Indep. _____ft. ☐ w/ device ☐ w/o device		☐ Standby Asst/Supervision	☐ w/ device ☐ w/o device
☐ Standby/Contact Assist	**Check all that apply**	☐ Smooth/Level Surfaces	☐ Contact Guard	☐ w/ device ☐ w/o device
☐ Min Assist		☐ Carpet	☐ Min Physical Asst	☐ w/ device ☐ w/o device
☐ Mod Asst		☐ Uneven Terrain	☐ Mod Physical Asst	☐ w/ device ☐ w/o device
☐ Max Asst		☐ Curbs, Stairs	☐ Max Physical Asst	☐ w/ device ☐ w/o device
☐ Dependent		☐ Ramps/Inclines	Distance _____ ft.	
		☐ Other	☐ Dependent / Unable to Ambulate	
Transfer Method	Ambulation fluctuates due to			
☐ Stand Pivot				
☐ Sit/Squat Pivot	**Comments**			
☐ Sliding Board				
☐ Lift / Sling Required				
☐ Recommend transfer training	Timed Up and Go Test _____ sec. [60-69 yo. = 8.1sec (7.1-9.0), 70-79 yo. = 9.2 sec (8.2-10.2), 70-99 yo. = 11.3 sec (10.0-12.7)]			
	Fall History: # of falls in the past 6 mo. _____ # of "near" falls in the past 6 mo. _____			

EXPLAIN WHY PATIENT IS NON-AMBULATORY or NOT A FUNCTIONAL AMBULATOR	
☐ Cardiac System	**Comments**
☐ Circulatory System	
☐ Musculoskeletal Sys	
☐ Neuromuscular Sys	
☐ Pulmonary System	
☐	

WHEELCHAIR SKILLS (Shown by Trial)

	Indep	Assist	Dependent Unable	N/A*		
Manual W/C Propulsion Device trialed ☐ *MWC ruled out due to	☐	☐	☐	☐	☐ Safe ☐ Timely Distance _____ft.	
☐ Able to propel the MWC forward ☐ Able to propel the MWC in reverse ☐ Able to propel the MWC turning right / turning left ☐ Recommend MWC w/c skills training ☐ Recommend dependent MWC (stroller / tilt in space)						**Method** Arm ☐ Left ☐ Right ☐ Both Foot ☐ Left ☐ Right ☐ Both

Power Assist Propulsion Skills
Device trialed

	Indep	Assist	Dependent Unable	N/A*		
Operate Scooter (POV) Device trialed ☐ *POV ruled out due to ☐ Inability to safely transfer indep. ☐ Inability to sit in and use POV ☐ Inability to operate the tiller ☐ Home does not support its use ☐ Other	☐	☐	☐	☐	☐ Safe ☐ Timely Distance _____ft.	
☐ Able to operate the POV forward ☐ Able to operate the POV in reverse ☐ Able to operate the POV turning right / turning left ☐ Able to transfer to / from POV independently ☐ Able to sit on and operate POV independently ☐ Recommend POV skills training						**Comments**

FEATURES REQUIRED FOR SAFE USE OF POV

	Indep	Assist	Dependent Unable	N/A*		
Operate PWC Device trialed ☐ *PWC ruled out due to ☐ Lower lever equipment meets patient's current mobility needs ☐ Other	☐	☐	☐	☐	☐ Safe ☐ Timely Distance _____ft.	
☐ Able to operate the PWC forward ☐ Able to operate the PWC in reverse ☐ Able to operate the PWC turning right / turning left ☐ Recommend PWC w/c skills training						**Comments**

EQUIPMENT TRIALS AND RESULTS

SUMMARY: The least costly alternative for safe, functional and independent mobility was found to be:
☐ Crutch/Cane ☐ Walker ☐ Manual w/c ☐ Dependent care mobility device (stroller/tilt-in-space)
☐ Manual w/c with power assist ☐ Scooter ☐ Standard Power w/c ☐ Complex Rehab power w/c

Goals for Wheelchair Mobility and Seating System
- ☐ Maximize independence with mobility in the home with mobility related ADLs (MRADLs)
- ☐ Maximize independence with mobility at school, work and/or in the community
- ☐ Dependent mobility for safe transport
- ☐ Provide independent pressure relief
- ☐ Provide tilt to facilitate pressure relief, postural control, and physiological functioning
- ☐ Provide recline to facilitate pressure relief, postural control, physiological functioning, ADL care
- ☐ Optimize pressure re-distribution
- ☐ Provide support needed to facilitate function or safety
- ☐ Provide corrective forces to assist with maintaining or improving posture
- ☐ Accommodate client's posture- Current seated postures and positions are not reducible or will not tolerate corrective forces
- ☐ Client to be independent with relieving pressure in the wheelchair
- ☐ Enhance physiological function such as breathing, swallowing, digestion and/or bowel/bladder elimination
- ☐ Manage tone/spasticity
- ☐ Manage pain
- ☐ Prevent medical complications and injury
- ☐ Enhance ability to live in the community rather than as institution
- ☐ Other
- ☐ Other

Comments

EQUIPMENT RECOMMENDATIONS and JUSTIFICATION

MOBILITY BASE	JUSTIFICATION	
Manufacturer _____ **Model** _____ **Color** _____ Seat Width _____ Seat Depth _____ Seat to Floor Height _____ Can be grown to _____ Length of need _____	☐ provide transport from point A to B ☐ promote independent mobility ☐ not a safe, functional ambulator ☐ walker or cane inadequate ☐ non-ambulatory/cannot walk ☐ enhance ability to live in the community rather than an institution ☐ other	☐ width/depth necessary to accommodate anatomical measurement(s) ☐ equipment is a lifetime medical need ☐ decrease caregiver burden ☐ prevent medical complications ☐ manage pain ☐ maximize independence and self-determination
☐ **Standard Manual Wheelchair Base** ☐ **Travel Base** ☐ **Dependent Base**	☐ non-functional ambulator ☐ able to self-propel in residence ☐ unable to self-propel in residence	☐ non-ambulatory/cannot walk ☐
☐ **Lightweight Manual Wheelchair**	☐ self-propulsion ☐ medical condition/weight of w/c affect ability to self-propel standard MWC ☐ marginal propulsion skills/can and does self-propel ☐ wheelchair fits throughout house	☐ willing and motivated to use ☐ seat to floor height required to foot propel ☐
☐ **High-strength Lightweight MWC** ☐ **Hemi-height**	☐ self-propulsion ☐ medical condition/weight of w/c affect ability to self-propel standard MWC ☐ full-time daily use ☐ lower seat to floor height required to propel with foot/feet ☐ short stature	☐ requires features not available on a lightweight manual w/c ☐ requires a specific seat width, depth, or height ☐ willing and motivated to use ☐ required to load w/c into vehicle ☐
☐ **Ultra-lightweight MWC** **Axle Position Adjustment Required** **Vertical** ☐ UE biomechanics (100°-120° degree elbow flexion) ☐ seat slope (dump) for propulsion, balance or pelvic stability **Horizontal** ☐ stroke length ☐ reduce weight on casters **Rotational** ☐ lateral stability	☐ 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 ☐ improved UE access to wheels ☐ reduce UE overuse injury ☐ full time w/c user for ADLs ☐ increase ability to perform high-level wheelchair skills ☐ amputee placement ☐	☐ improved postural stability by changing angle ☐ change axle position with increased proficiency of use ☐ allow seat to back angle changes ☐ adjust center of gravity ☐ increase stability in wheelchair ☐ increase growth adjustability due to axle changes ☐ decrease footprint of w/c for increased maneuverability
☐ **Heavy-duty Manual Wheelchair** ☐ **Extra Heavy-duty MWC**	☐ accommodate user weight ☐	☐ broken frame on previous chair ☐ extreme tone ☐ excess movement
☐ **Stroller Base**	☐ infant/child ☐ unable to propel MWC ☐ independent mobility is not a goal currently ☐ unable to safely operate a PMD	☐ non-functional ambulator ☐ non-functional UE ☐
☐ **Power Assist**	☐ cannot functionally operate a manual wheelchair ☐ shoulder pain during manual w/c propulsion ☐ less expensive option to POV/PWC ☐ repetitive strain injury in shoulder girdle ☐ requires conservation of energy to participate in MRADLs	☐ unable to propel up ramps or curbs using a manual wheelchair ☐ unwilling to use power wheelchair ☐ has been using ultralight wheelchair base for more than a year ☐ home or transportation does not accommodate a power wheelchair ☐
☐ **Scooter/POV**	☐ non-ambulatory ☐ non-functional ambulator ☐ cannot functionally propel MWC ☐	☐ has adequate trunk stability ☐ can safely operate & is willing to ☐ can safely transfer ☐ home environment supports use

MOBILITY BASE	JUSTIFICATION	
☐ **Power Wheelchair** ☐ **Group 1 PWC** ☐ **Group 2 PWC** ☐ **Group 3 PWC** required for suspension to ☐ minimize pain ☐ manage tone/spasticity ☐ mitigate reflex activity ☐ maintain balance/upright sitting ☐ maintain posture/position/head control ☐ maintain contact with drive control ☐ ☐ **Group 4 PWC** ☐ **Group 5 PWC** for pediatric use	☐ non-ambulatory ☐ non-functional ambulator ☐ cannot functionally propel MWC ☐ cannot functionally and/or safely operate scooter/POV ☐ home environment does not support the use of a POV ☐ home environment supports use of power wheelchair ☐ can safely operate & is willing to ☐ can safely transfer/be transferred ☐	☐ requires speed adjustability ☐ requires torque adjustability ☐ requires sensitivity adjustability ☐ requires acceleration adjustability ☐ requires braking adjustability ☐ requires expandable electronics ☐ requires alternative drive control ☐ required to negotiate an incline of _____° ☐ required to negotiate obstacles/ threshold of _____in. ☐ required to traverse distances/terrain

SEAT FUNCTIONS/POSITION CHANGES	JUSTIFICATION	
☐ **Tilt Base or Tilt Feature Added** ☐ Forward ☐ Rearward ☐ Lateral ☐ Powered tilt on power chair ☐ Powered tilt on manual chair ☐ Manual tilt on manual base ☐ Manual tilt on power base	☐ change position against gravitational force on head/trunk ☐ change position for pressure redistribution/cannot weight shift ☐ improve chewing, swallowing and/or digestion ☐ minimize risk of aspiration ☐ decrease respiratory distress ☐ facilitate visual orientation ☐ decrease pain ☐ blood pressure management	☐ increase sitting tolerance ☐ facilitate safe transfers ☐ manage tone/spasticity ☐ rest periods/inability to transfer out of chair for rest ☐ assist/maintain postural alignment ☐ facilitate postural control ☐ maintain vital organ capacity ☐ manage autonomic dysreflexia ☐ manage orthostatic hypotension ☐
☐ **Recline** ☐ Semi (>15° but < 80°) ☐ Full (> 80°) ☐ Power recline on power base ☐ Power recline on manual base ☐ Manual recline on manual base ☐ Manual recline on power base	☐ accommodate femur to back angle ☐ full pressure redistribution/cannot weight shift ☐ head/neck positioning/support ☐ maintain muscle length/joint ROM ☐ manage tone/spasticity ☐ blood pressure management ☐ decrease respiratory distress ☐ manage bowel/bladder/catheter care, intermittent catheterization, undergarment, change ☐ facilitate safe transfers ☐ participation in ADL care ☐	☐ recumbent rest periods and sleeping in wheelchair ☐ repositioning ☐ increase sitting tolerance ☐ facilitate postural control ☐ use in conjunction with elevating leg rests to raise LE above heart to manage edema ☐ improve circulation ☐ decrease pain ☐ use in conjunction with tilt for optimal pressure redistribution as tilt alone does not accomplish effective pressure relief/ reperfusion
☐ **Power Anterior Tilt** ☐ **Power Adj. Seat Height** ☐ **Power Standing Feature**	☐ increase independence in transfers ☐ minimize risk of fall/injury in transfers ☐ increase independence in ADLs ☐ increase functional reach ☐ minimize over shoulder reach and risk for overuse injury ☐ decrease hyper lordotic neck position ☐ minimize eliciting STNR ☐ decrease pain ☐ improve bathroom function and safety ☐	☐ facilitate level eye position while communicating ☐ drive at elevated height for improved line of sight and safety ☐ increased weight bearing ☐ decrease joint contractures ☐ improve digestion and elimination ☐ provide pressure distribution away from scapula, sacrum, coccyx, and ischial tuberosities ☐ support educational/vocational goals
☐ **Power Leg Elevation** ☐ Center mount foot platform ☐ Center mount foot platform w/ articulation ☐ Elevating legrests ☐ Elevating legrests w/ articulation	☐ manage LE edema ☐ improve circulation ☐ maintain LE muscle length/joint ROM ☐ position LEs at 90° when upright, not available with standard power ELRs ☐ indep. operation of ELRs needed, not available with center mount ☐ elevate LEs during tilt, recline or tilt and recline	☐ maintain feet on footplate ☐ increase ground clearance over thresholds, curbs or uneven terrain ☐ center mount tucks into chair to decrease turning radius in the home- not available with ELRs ☐ physically unable to operate manual elevating leg rests ☐

ADDITIONAL INFORMATION ON POWER SEATING FUNCTIONS

PWC ELECTRONICS	JUSTIFICATION	
Control/input device ☐ Proportional ☐ Standard joystick ☐ Expandable joystick ☐ Specialty joystick (i.e., mini, compact) ☐ Head control ☐ Chin control ☐ Other extremity control ☐ _____ ☐ Specialty joystick handle ☐ Non-proportional ☐ Electrical switches ☐ Mechanical switches ☐ Head array ☐ Sip and puff ☐ ☐ Combination ☐ Head array sip and puff ☐ ☐ Other _____ Body Part(s) _____ ☐ Left ☐ Right	☐ provides access for controlling pwc ☐ required as part of an expandable system ☐ unable to generate sufficient force to operate a standard joystick ☐ limited movement/strength to operate a standard joystick ☐ required to operate the pwc with the head, chin or other body part ☐ unable to use a std joystick handle ☐ lacks motor control to operate proportional drive control ☐ unable to understand prop. controls ☐ lacks UE function for prop. controls ☐ needed to operate control using air pressure through straw, tube, or wand ☐ progressive disease/changing condition ☐	☐
☐ **expandable controller/ wire harness**	☐ required for proper set-up of electronics with multiple power seat functions (≥ 3 actuators)	☐ harness is required with an expandable controller to provide necessary connectors for operation
☐ **Through drive control operation of power seat functions**	☐ required to operate one power seat function with an alternative drive control device ☐ required to operate two or more power seat functions with an alternative drive control device ☐	☐ uses a joystick and is unable to operate a switch throughout the full range of tilt or recline ☐ uses a joystick and is unable to operate a switch throughout the full range of two or more power seat functions
☐ **Display box**	☐ necessary for alternate controls	☐ allows user to see mode/ drive profile
☐ **Tracking technology**	☐ to minimize the need for excessive movements to drive the chair over thresholds and on uneven surfaces ☐ required for use with non-proportional drive control to minimize the need for excessive drive commands ☐ for safety when using a latched driving system ☐	☐ lack of strength to make constant corrections to safely progress in a straight line forward ☐ lack of endurance to make constant corrections to safely progress in a straight line forward ☐ lack of coordination to make constant corrections to safely progress in a straight line forward
☐ **Mount for switches** ☐ **Mount for joystick**	☐ swing away for safe transfers ☐	☐ attaches joystick, switches to w/c ☐ provides for consistent access
☐ **Attendant controlled joystick and mount**	☐ allow caregiver to control wheelchair In case of medical emergency or chair malfunction ☐ user requires assistance for safety in unfamiliar environments ☐ user is no longer able to operate drive control device throughout the day	☐ compliance with transportation regulations ☐ allow age/developmentally appropriate assistance when driving ☐
☐ **Batteries / charger**	☐ required to power base	☐ charge battery for wheelchair
☐ **Ventilator battery**	☐ required to power ventilator	☐
☐ **Lights**	☐ safe operation within the home once dwelling lights are turned off ☐	☐ increase visibility at night or during inclement weather ☐ increased safety crossing street
☐ **Other**	☐	

MOBILITY BASE COMPONENTS	JUSTIFICATION	
☐ **Angle adjustable back** ☐ **Depth adjustable back** ☐ **Height adjustable back**	☐ postural control ☐ control of tone/spasticity ☐ accommodate range of motion ☐	☐ UE functional control ☐ accommodate seating system ☐ accommodate growth
☐ **Dynamic Back**	☐ absorb forces exerted by user to improve durability of equipment ☐ absorb forces exerted by the user to prevent loss of position in seating sys ☐	☐ provide movement to decrease agitation ☐ provide sensory input ☐ enhance voluntary movement ☐ accommodate abnormal involuntary movement
☐ **Armrests** ☐ fixed ☐ adj. height ☐ removable ☐ swing away ☐ flip back ☐ reclining ☐ full length ☐ desk length ☐ tubular ☐ waterfall arm pad ☐ _____	☐ accommodate seat-elbow meas. ☐ provide support with elbow at 90° ☐ postural control / trunk support ☐ assist with pressure relief ☐ allow UEs to move w/ reclining back	☐ change height/angle for ADLs ☐ remove for transfers ☐ access to table ☐
☐ **Foot Platform/ Footrests/ Leg Rests** ☐ one-piece footplate/foot platform ☐ standard ☐ tapered ☐ V-style ☐ center mount ☐ footrests ☐ 60° ☐ 70° ☐ 80° ☐ 90° ☐ adjustable knee angle ☐ dynamic ☐ heavy duty ☐ fixed ☐ removable ☐ swing-away ☐ manual elevating ☐ articulating	☐ provide LE support ☐ enable safe transfers ☐ accommodate knee ROM limitation(s) ☐ maintain muscle length/joint ROM ☐ provide change in position for legs ☐ maintain feet on footplate ☐ independent LE positioning R /L ☐ manage tone/spasticity ☐ improve circulation ☐ use in conjunction with tilt, recline or tilt and recline to decrease edema ☐	☐ provide sensory input ☐ accommodate involuntary movement ☐ provide movement to decrease agitation ☐ absorb forces by user to increase durability of equipment ☐ absorb forces by user to prevent loss of position in seating system ☐ absorb movement without resistance to control tone
☐ **Foot Support** ☐ flip up ☐ fixed/rigid ☐ adjustable angle ☐ R ☐ L ☐ multi-adjustable angle ☐ R ☐ L ☐ dynamic ☐ contracture support	☐ provide foot support ☐ accommodate ankle ROM ☐ provide foot support with proper pressure distribution ☐ allow foot to go under w/c base ☐ facilitate safe transfers ☐	☐ accommodate/facilitate movement ☐ absorb forces by user to prevent loss of position in seating system ☐ absorb forces by user to increase durability of equipment ☐ prevent foot/feet from falling off foot support
Propulsion wheel Size **Spokes** ☐ mag ☐ spokes ☐	☐ increase access to wheel ☐ allow seating system to fit on base ☐ accommodate seat to floor height ☐ decrease overall weight of w/c ☐	☐ increase propulsion ability ☐ maintenance free ☐ larger wheel improves ability to negotiate thresholds/uneven terrain ☐ decrease wt. for loading into vehicle
Propulsion tires ☐ pneumatic ☐ semi-pneumatic ☐ flat free inserts ☐ solid ☐	☐ decrease maintenance ☐ prevent frequent flats ☐ user unable to maintain air in tires ☐ decrease rolling resistance	☐ increase shock absorbency ☐ decrease pain ☐ decrease spasms ☐
Wheel rims / Hand rims ☐ metal ☐ plastic coated ☐ ergonomic **Projections** ☐ oblique ☐ vertical	☐ increase self-propulsion with hand weakness/decreased grasp ☐ provide ability to propel wheelchair	☐ reduce/mitigate carpal tunnel syndrome ☐
☐ **Alternative propulsion methods** ☐ one armed drive ☐ R ☐ L ☐ lever activated ☐ gear reduction	☐ enable propulsion of manual wheelchair with one arm ☐ functional use of only one UE ☐	☐ decrease shoulder pain ☐ increase energy efficiency for self-propulsion
☐ **Quick release axle**	☐ allows wheels to be removed to decrease size for storage	☐ decrease weight for lifting ☐
☐ **Amputee adapter**	☐ unable to counterbalance in w/c due to loss of LE	☐ increase rearward stability ☐
☐ **Spoke protector**	☐ protect hand/fingers from injury	☐
☐ **Wheel locks** ☐ push ☐ pull ☐ scissor ☐ hub ☐ foot Extension ☐ R ☐ L	☐ stabilize wheel for transfers ☐ lock wheels to prevent rolling ☐ independent in applying wheel locks due to decreased reach or strength	☐ allows complete wheel clearance in unlocked position to prevent injury during propulsion ☐

MOBILITY BASE COMPONENTS	JUSTIFICATION	
Casters **Size** _____ ☐ fixed caster housing ☐ adj caster housing ☐ shock absorbing casters **Caster tires** ☐ pneumatic ☐ semi-pneumatic ☐ flat free inserts ☐ solid ☐ poly ☐ soft roll ☐	☐ maneuverability ☐ stability of wheelchair ☐ accommodate seat to floor height ☐ durability ☐ maintenance free/prevent flats ☐ angle adjustment for postural control ☐ decrease rolling resistance ☐ keep user weight evenly distributed for decreased energy expenditure	☐ increase shock absorbency ☐ decrease pain ☐ decrease spasms ☐ increase leverage for improved obstacle and transition management ☐ decrease fatigue from road shock ☐ decrease weight for more effective propulsion
☐ **Shock absorbers/ suspension**	☐ decrease vibration ☐ decrease pain ☐	☐ decrease spasticity ☐ increase sitting tolerance
☐ **Specific seat height** Front _____ Back _____	☐ foot propulsion ☐ transfers ☐ postural stability	☐ accommodation of lower leg length ☐
☐ **Anti-tipping device(s)**	☐ minimize risk for rearward displacement or tipping	☐ minimize risk for forward displacement or tipping
☐ **Side guards**	☐ prevent skin tears/abrasions ☐ prevent body parts from becoming caught in wheel causing injury	☐ provide hip and pelvic stabilization ☐ prevent clothing from getting caught in wheel causing injury
☐ **Transportation tie-down option**	☐ crash tested brackets for safety	☐
☐ **Rear cane/ Push handles** ☐ standard ☐ angle adjustable ☐ extended ☐ dynamic	☐ caregiver access ☐ caregiver assist ☐	☐ allows "hooking" to maintain balance, perform pressure relief and participate in ADLs
☐ **Canopy**	☐ protect user from the elements ☐ regulate sensory input	☐ user has light sensitivity ☐
☐ **Crutch/Cane holder** ☐ **IV hanger** ☐ **Cylinder holder** ☐ **Vent tray**	☐ stabilize ventilator/accessory on wheelchair	☐ user is dependent on device ☐

SEATING / POSITIONING COMPONENTS

COMPONENT	Mfg/model/size	JUSTIFICATION	
☐ **Seat cushion**		☐ accommodate impaired sensation ☐ decubitus ulcers present ☐ history of decubitus ulcers ☐ increase pressure distribution ☐	☐ stabilize pelvis ☐ prevent pelvic extension ☐ accommodate obliquity/rotation ☐ accommodate multiple deformity ☐ promote hip/femur alignment
☐ **Seat cushion – Custom Molded**		☐ custom seat cushion required "off the shelf" will not accommodate deformity	☐
☐ **Additional seat components**		☐	
☐ **Seat wedge**		☐ accommodate ROM limitations ☐	☐ aggressive seat shape to decrease sliding down in the seat
☐ **Cover replacement**		☐ protect back or seat cushion	☐
☐ **Seat board** ☐ **Seat platform** ☐ **Back board**		☐ support cushion to prevent hammocking of upholstery ☐	☐ attach cushion/back to base ☐ accommodate seat to floor height
☐ **Back support**		☐ provide posterior trunk support ☐ provide posterior/lateral trunk support ☐ accommodate deformity ☐ accommodate or decrease tone ☐ facilitate tone	☐ provide lumbar/sacral support ☐ support trunk in midline ☐ pressure relief over spinous processes ☐
☐ **Back cushion – Custom Molded**		☐ custom back cushion required "off the shelf" will not accommodate deformity	☐
☐ **Additional back components**		☐	☐
☐ **Mounting hardware** ☐ seat ☐ back ☐ removeable ☐ fixed ☐ swing away ☐ dynamic		☐ attach seat platform/cushion ☐ attach back platform/cushion ☐	☐ sensory input ☐ accommodate/facilitate movement ☐

COMPONENT	Mfg/model/size	JUSTIFICATION	
☐ **Pelvic positioner** ☐ Single pull belt ☐ Dual pull belt ☐ Specialized belt ☐ SubASIS bar ☐ _____		☐ stabilize pelvis in neutral rotation ☐ neutralize destructive postural tendency ☐ counteract rotation ☐ counteract obliquity ☐ maintain contact with w/c cushion	☐ pad for protection over boney Prominence(s) ☐ special pull angle to control tilt, rotation and/or obliquity ☐
☐ **Lateral pelvic support** ☐ R ☐ L		☐ pelvis in neutral ☐ accommodate pelvic deformity	☐ accommodate tone ☐
☐ **Lateral pelvic support hardware** ☐ removeable ☐ fixed ☐ swing away ☐ dynamic		☐ remove/swing-away for safe transfers ☐	☐ accommodate/facilitate movement
☐ **Lateral thigh/ knee support** ☐ R ☐ L		☐ position thighs in alignment ☐ accommodate windswept deformity ☐	☐ decrease LE abduction
☐ **Lateral thigh/knee support hardware** ☐ removeable ☐ fixed ☐ swing away ☐ dynamic		☐ remove/swing-away for safe transfers ☐	☐ accommodate/facilitate movement
☐ **Medial thigh/ knee support**		☐ decrease adduction ☐ accommodate ROM limitations	☐ accommodate windswept deformity ☐
☐ **Medial thigh/ knee support hardware** ☐ removeable ☐ fixed ☐ swing away/flip down ☐ dynamic		☐ remove/swing-away for safe transfers ☐	☐ accommodate/facilitate movement
☐ **Foot support** ☐ **Foot box** ☐ **Shoe holder(s)** ☐ R ☐ L		☐ position foot ☐ accommodate deformity ☐	☐ provide stability ☐ decrease tone ☐ control position
☐ **Ankle strap** ☐ **Toe strap** ☐ **Heel loops** ☐ **Calf Strap**		☐ support foot on foot rest ☐ decrease extraneous movement ☐ position/ support foot ☐	☐ provide input to heel ☐ protect foot ☐ increase stability ☐ inhibit abnormal tone patterns
☐ **Lateral thoracic Supports** ☐ R ☐ L		☐ decrease lateral trunk leaning ☐ accommodate asymmetry ☐ contour for increased contact	☐ safety ☐ control of tone/spasticity ☐
☐ **Anterior chest strap, vest, or shoulder retractors**		☐ decrease forward movement of shoulder ☐ accommodate of TLSO ☐ decrease forward movement of trunk ☐ accommodate/facilitate movement	☐ added abdominal support ☐ alignment ☐ assistance with shoulder control ☐ decrease shoulder elevation ☐ increase trunk stability
☐ **Headrest**		☐ support during tilt and/or recline ☐ provide posterior head support ☐ provide posterior neck support ☐ provide lateral head support ☐ provide anterior head support ☐ placement of switches	☐ accommodate ROM limitations ☐ improve respiration ☐ improve chewing/swallowing ☐ accommodate tone/spasticity ☐ improve visual orientation ☐
☐ **Neck support**		☐ decrease neck rotation ☐	☐ decrease forward neck flexion
☐ **Headrest hardware** ☐ removeable ☐ fixed ☐ swing away/flip back ☐ multi-axis adjustable ☐ dynamic		☐ mount headrest to back/base ☐ mount headrest swing away lateral head/facial supports ☐ mount anterior head support ☐ mount switches ☐ swing away, flip back or remove for safe transfers ☐	☐ accommodate ROM limitations ☐ sensory input ☐ accommodate involuntary movement ☐ help absorb forces by user to increase durability of equipment ☐ enhance functional movement

COMPONENT	Mfg/model/size	JUSTIFICATION	
☐ **Upper extremity support** ☐ Arm trough ☐ R ☐ L ☐ Hand support ☐ ½ tray ☐ R ☐ L ☐ Full tray ☐ swivel mount ☐ joystick cutout ☐ elbow block ☐ R ☐ L ☐ wrist straps ☐ R ☐ L		☐ decrease UE edema ☐ reduce shoulder subluxation ☐ decrease gravitational pull on shoulder joint ☐ control tone/spasticity ☐ support midline trunk positioning ☐ provide support for UE function ☐ maintain hand in natural position ☐	☐ help prevent UE from falling off support during tilt and/or recline ☐ help prevent UE from striking objects in the environment, prevent injury ☐ allow proper placement of tray without interference with controller ☐ access to AAC/ Computer/ EADL or another AT device ☐
☐ **Essential needs bag or pouch**		Required to hold, and provide access to medically necessary ☐ medicine ☐ special food ☐ orthotics	☐ diapers/undergarments ☐ catheter and hygiene supplies ☐ ostomy and hygiene supplies ☐ clothing for changes/weather ☐
☐ **Other**			
☐ **Other**			
☐ **Other**			

ADDITIONAL INFORMATION

Follow-up / Plan of Care

Patient Name Printed		
Patient/Caregiver* Signature		**Date**
***Caregiver Relationship to Patient**		

☐ I, the above signed patient, certify that I am willing and able to use the recommended equipment.

Therapist Name Printed		**Lic. #**
Therapist's Signature		**Date**
Supplier's Name Printed		**ATP #**
Supplier's Signature		**Date**

Therapist email and contact for reviewer

This is to certify that I, the above signed therapist, have the following affiliations
☐ DME Supplier ☐ Mfg. of Recommended Eq. ☐ Patient's LTC Facility ☐ None

I concur with the above findings and recommendations of the therapist and supplier

Physician's Name Printed and preferred contact		**Physician specialty**
Physician's Signature		**Date**