

Seating/Mobility Evaluation

To be completed by Physiatrist or Physical/Occupational Therapist
In Association With Mobility Device Specialist

PATIENT INFORMATION:

Name:	DOB:	Sex:	Evaluation Date:
Address:	Physician:		<i>This form will serve as the LMN for the following suppliers:</i> Primary : Contact Name : Phone #:
	Mobility Device Therapist:		
Phone #:	License #:	Phone #:	
Spouse/Parent/Caregiver/Guardian Name:	Mobility Device Specialist: Title, & Phone #:		Rehabilitation Engineering Program or 2nd Supplier: Contact Name: Phone #:
Relationship:	Primary Therapist: Phone #:		
Phone #:	Insurance/Payer: Patient Recipient #:		
Reason for Referral			
Patient Goals:			
Caregiver Goals and Specific Limitations that May Effect Care:			

MEDICAL HISTORY:

Primary Diagnosis:	Onset:	
Secondary Diagnoses :		
<input type="checkbox"/> Progressive Disease	Relevant Past and Future Surgeries:	
Height:	Weight:	Describe Changes Past 2-5 years – Include Seating Measurements If Relevant:
Cardio Status: _____ Functional Limitations: _____		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Severely Impaired <input type="checkbox"/> NA		
Respiratory Status: _____ Functional Limitations: _____		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Severely Impaired <input type="checkbox"/> NA		
Orthotics: _____ Amputee <input type="checkbox"/> Yes <input type="checkbox"/> No		

HOME ENVIRONMENT:

<input type="checkbox"/> House <input type="checkbox"/> Condo/Town Home <input type="checkbox"/> Apartment <input type="checkbox"/> Asst Living <input type="checkbox"/> LTCF <input type="checkbox"/> Own <input type="checkbox"/> Rent	
<input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Others (Who?)	Hours with caregiver: _____
<input type="checkbox"/> Home is Accessible to Equipment Storage of Wheelchair: <input type="checkbox"/> In Home <input type="checkbox"/> Other Stairs: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Comments:(Describe management of equipment if stairs present – Describe security of Storage if Other is Checked)	

Patient Name:

COMMUNITY ADL:

TRANSPORTATION:	
<input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Public Transportation <input type="checkbox"/> Adapted W/C Lift <input type="checkbox"/> Ambulance <input type="checkbox"/> Other: <input type="checkbox"/> Sits in Wheelchair During Transport	
Where is W/C Stored During Transport?	<input type="checkbox"/> Tie Downs
<input type="checkbox"/> Self Driver Drive While in Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employment:	
Specific Requirements Pertaining to Mobility	
School:	
Specific Requirements Pertaining to Mobility	
Other:	

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> NA Comments:
Visual Acuity is Adequate For Safe Wheelchair Operation: [] Yes [] No
Processing Skills are Adequate for Safe Wheelchair Operation: [] Yes [] No
Comments – Describe Limitations:

COMMUNICATION:

Verbal Communication <input type="checkbox"/> WFL Receptive <input type="checkbox"/> WFL Expressive <input type="checkbox"/> Understandable <input type="checkbox"/> Difficult to Understand <input type="checkbox"/> Non-Communicative
<input type="checkbox"/> Uses an Augmentative Communication Device Manufacturer/Model :
AAC Mount Needed:

SENSATION and SKIN ISSUES:

Sensation <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hyposensate <input type="checkbox"/> Hypersensate <input type="checkbox"/> Defensiveness Level of sensation:		Pressure Relief: Able to Perform Effective Pressure Relief : <input type="checkbox"/> Yes <input type="checkbox"/> No Method: If not, Why?:	
Skin Issues/Skin Integrity Current Skin Issues <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Intact <input type="checkbox"/> Red Area <input type="checkbox"/> Open Area <input type="checkbox"/> Scar Tissue <input type="checkbox"/> At Risk from Prolonged Sitting Where _____		History of Skin Issues <input type="checkbox"/> Yes <input type="checkbox"/> No Where _____ When _____	Hx of Skin Flap Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No Where _____ When _____
Complaint of Pain: (Describe Location, Severity (Scale 1-10), Acute or Chronic, And How It Interferes With Ability To Operate Equip.)			

ADL STATUS (In Reference to Wheelchair Use):

	Indep	Assist	Unable	Indep with Equip	Not Assessed	Comments
Dressing						
Eating						Describe Oral Motor Skills
Grooming/Hygiene						
Meal Prep						
IADLS						
Bowel Mngmnt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						Comments:
Bladder Mngmnt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						Comments:

Patient Name:

CURRENT SEATING / MOBILITY:

Current Mobility Base: <input type="checkbox"/> None <input type="checkbox"/> Dependent <input type="checkbox"/> Dependent with Tilt <input type="checkbox"/> Manual <input type="checkbox"/> Scooter <input type="checkbox"/> Power Type of Control:				
Manufacturer:		Size:	Model:	Serial #:
Pediatric [] Adult []		Color:	Age:	
Current Condition of Mobility Base:				
Current Seating System:			Age of Seating System:	
COMPONENT		MANUFACTURER/CONDITION		
Seat Base				
Cushion				
Back				
Lateral Trunk Supports				
Thigh Support				
Knee Support				
Foot Support				
Foot Strap				
Head Support				
Pelvic Stabilization				
Anterior Chest/Shoulder Support				
UE Support				
Other (Tilt/Recline, etc.)				
When Relevant:	Overall Seat Height	Overall W/C Length	Overall W/C Width	
Describe Posture in Present Seating System:				
Number of Hours/Day Spent in Wheelchair?				

WHEELCHAIR SKILLS: (Shown by Trial) PT. IS TOTALLY DEPENDENT FOR MOBILITY YES [] NO []

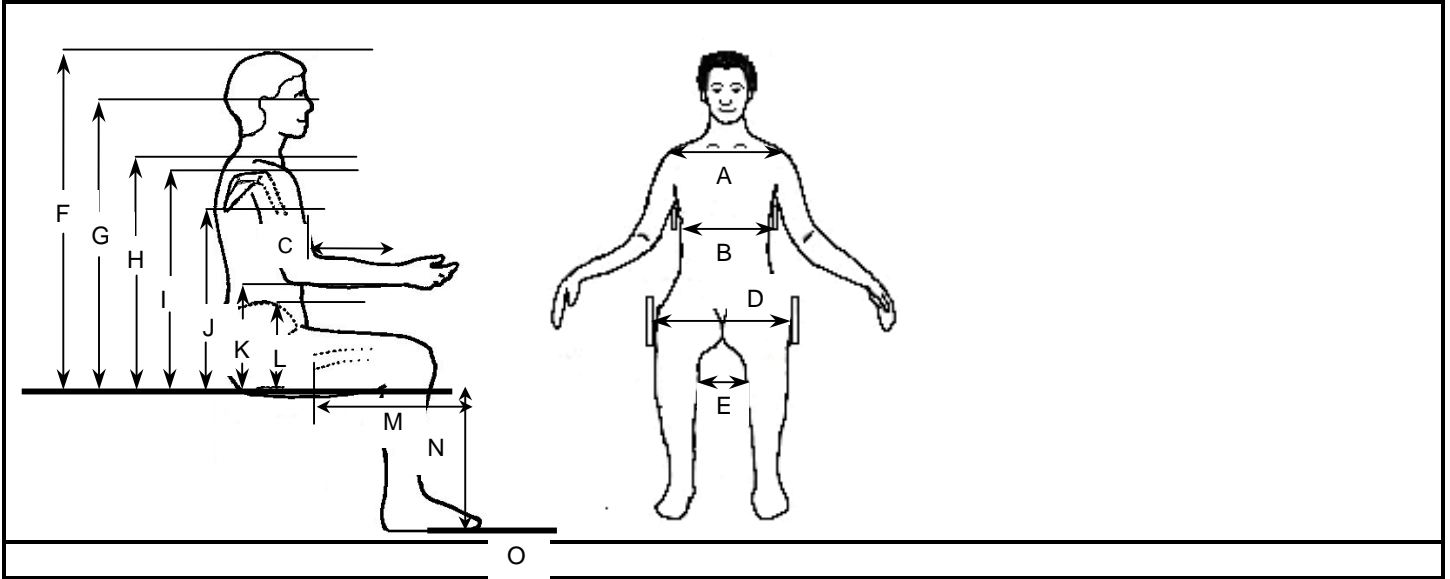
	Indep	Assist	Dependent/Unable	N/A	Comments
Bed ↔ W/C Chair Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
w/c ↔ Commode Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Manual w/c Propulsion:	<input type="checkbox"/> UE or LE Strength and Endurance Sufficient to Participate in ADLs Using Manual Wheelchair				Arm : <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Foot: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Operate Scooter	<input type="checkbox"/> Strength, Hand Grip, Balance, Transfer Appropriate for Use. <input type="checkbox"/> Living Environment Appropriate for Scooter Use.				
Operate Power W/C: Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance
Operate Power W/C: w/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance

MOBILITY/BALANCE:

Balance		Transfers		Ambulation	
Sitting Balance:	Standing Balance	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent		
<input type="checkbox"/> WFL	<input type="checkbox"/> WFL	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Ambulates with Asst	
<input type="checkbox"/> Uses UE for Balance in Sitting	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Mod Asst	<input type="checkbox"/> Mod Asst	<input type="checkbox"/> Ambulates with Device	
<input type="checkbox"/> Min Assist	<input type="checkbox"/> Mod Assist	<input type="checkbox"/> Max Assist	<input type="checkbox"/> Max Assist	<input type="checkbox"/> Indep. Short Distance Only	
<input type="checkbox"/> Mod Assist	<input type="checkbox"/> Max Assist	<input type="checkbox"/> Dependent	<input type="checkbox"/> Dependent	<input type="checkbox"/> Unable to Ambulate	
<input type="checkbox"/> Max Assist	<input type="checkbox"/> Unable	<input type="checkbox"/> Sliding Board	<input type="checkbox"/> Sliding Board		
<input type="checkbox"/> Unable		<input type="checkbox"/> Lift / Sling Required	<input type="checkbox"/> Lift / Sling Required		
Comments:					

Patient Name:

MAT EVALUATION:



Measurements in Sitting:		Left	Right	
A:	Shoulder Width			
B:	Chest Width			
C:	Chest Depth (Front - Back)			H: Seat to Top of Shoulder
D:	Hip width			I: Acromium Process (Tip of Shoulder)
E:	Between Knees			J: Inferior Angle of Scapula
F:	Top of Head			K: Seat to Elbow
G:	Occiput			L: Seat to Iliac Crest
++	Overall width (asymmetrical width for windswept legs or scoliotic posture)			M: Upper leg length
				N: Lower leg length
				O: Foot Length









Additional Comments:

Hamstring flexibility: Pelvis to thigh angle accommodate greater than 90 **Thigh to calf angle** accommodate less than 90

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

EXPLAIN WHY PATIENT IS NON-AMBULATORY:

Patient Name:

POSTURE:			COMMENTS:
P E L V I S	Anterior / Posterior	Obliquity	Rotation-Pelvis
	 <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	 <input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> L elev <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	 <input type="checkbox"/> WFL <input type="checkbox"/> Right Anterior <input type="checkbox"/> Left Anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible
T R U N K	Anterior / Posterior	Left Right	Rotation-shoulders and upper trunk
	 <input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic Kyphosis <input type="checkbox"/> ↑ Lumbar Lordosis <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	 <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right <input type="checkbox"/> c-curve <input type="checkbox"/> s-curve <input type="checkbox"/> multiple <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	 <input type="checkbox"/> Neutral <input type="checkbox"/> Left-anterior <input type="checkbox"/> Right-anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other
Describe LE Neurological Influence/Tone:			
H I P S	Position	Windswept	Hip Flexion/Extension Limitations:
	 <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct <input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible	 <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	Hip Internal/External Range of motion Limitations:
K N E E S & F E E T	Knee R.O.M.		Foot Positioning
	Left Right <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Limitations <input type="checkbox"/> Limitations		<input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R ROM concerns: Dorsi-Flexed <input type="checkbox"/> L <input type="checkbox"/> R Plantar Flexed <input type="checkbox"/> L <input type="checkbox"/> R Inversion <input type="checkbox"/> L <input type="checkbox"/> R Eversion <input type="checkbox"/> L <input type="checkbox"/> R

Patient Name:

POSTURE:			COMMENTS:	
HEAD & NECK	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated L <input type="checkbox"/> Lat Flexed L <input type="checkbox"/> Rotated R <input type="checkbox"/> Lat Flexed R <input type="checkbox"/> Cervical Hyperextension	<input type="checkbox"/> Good Head Control <input type="checkbox"/> Adequate Head Control <input type="checkbox"/> Limited Head Control <input type="checkbox"/> Absent Head Control	Describe Tone/Movement of head and Neck:	
U P P E R E X T R E M I T Y	SHOULDERS		Describe Tone/Movement of UE:	
	Left <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed	Right <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed		R.O.M. for Upper Extremity <input type="checkbox"/> WNL <input type="checkbox"/> WFL Limitations: UE Strength (X/5): <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Concerns:
	ELBOWS			R.O.M. Strength (X/5) Strength concerns:
WRIST & HAND	Left <input type="checkbox"/> Fisting	Right	Strength / Dexterity: (X/5)	

Goals for Wheelchair Mobility

- Independence with mobility in the home and mobility related ADLs (MRADLs) in the community
- Independence with MRADLs in the community
- Provide dependent mobility
- Provide recline
- Provide tilt

Goals for Seating system

- Optimize pressure 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 flexible or will not tolerate corrective forces
- Client to be independent with relieving pressure in the wheelchair
- Enhance physiological function such as breathing, swallowing, digestion

Equipment Trial: (Must be of adequate duration to demonstrate independence for patient with previous dependent mobility.)

Describe Duration and Location of Trial: _____

Patient Demonstrated Ability To Use Equipment Safely & Efficiently [] Yes [] No Comments: _____

State why other equipment was unsuccessful: _____

Patient Name:

RECOMMENDATIONS & JUSTIFICATION (Lowest Appropriate Group Must Be Recommended)

MOBILITY BASE	JUSTIFICATION	
Mfgr: _____ Model: _____ Seat Width _____ Seat Depth _____ Can Be Grown To: (Must Complete) Seat Width _____ Seat Depth _____	<input type="checkbox"/> provide transport from point A to B <input type="checkbox"/> promote Indep mobility <input type="checkbox"/> is not a safe, functional ambulator <input type="checkbox"/> walker or cane inadequate	<input type="checkbox"/> non-standard width/depth necessary to accommodate anatomical measurement <input type="checkbox"/>
<input type="checkbox"/> Manual Mobility Base	<input type="checkbox"/> non-functional ambulator	
<input type="checkbox"/> Scooter/POV	<input type="checkbox"/> can safely operate <input type="checkbox"/> can safely transfer	<input type="checkbox"/> has adequate trunk stability <input type="checkbox"/> can not functionally propel manual wheelchair
<input type="checkbox"/> Power Mobility Base	<input type="checkbox"/> non-ambulatory <input type="checkbox"/> can not functionally propel manual wheelchair	<input type="checkbox"/> can not functionally and safely operate scooter/POV
<input type="checkbox"/> Stroller Base	<input type="checkbox"/> infant/child <input type="checkbox"/> unable to propel manual wheelchair <input type="checkbox"/> allows for growth	<input type="checkbox"/> non-functional ambulator <input type="checkbox"/> non-functional UE <input type="checkbox"/> Indep mobility is not a goal at this time
Reasons This Particular WC Was Chosen for Patient? _____ _____		
Why Isn't a Lower Group Appropriate for Patient? _____ _____		
Tilt Base or added <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Powered tilt on powered chair <input type="checkbox"/> Powered tilt on manual chair <input type="checkbox"/> Manual tilt on manual base	<input type="checkbox"/> change position against gravitational force on head and shoulders <input type="checkbox"/> change position for pressure relief/can not weight shift <input type="checkbox"/> transfers	<input type="checkbox"/> management of tone <input type="checkbox"/> rest periods <input type="checkbox"/> control edema <input type="checkbox"/> facilitate postural control <input type="checkbox"/>
Recline <input type="checkbox"/> Power recline on power base <input type="checkbox"/> Manual recline on manual base	<input type="checkbox"/> accommodate femur to back angle <input type="checkbox"/> bring to full recline for ADL care <input type="checkbox"/> change position for pressure relief/can not weight shift	<input type="checkbox"/> rest periods <input type="checkbox"/> repositioning for transfers or clothing/diaper /catheter changes <input type="checkbox"/> head positioning
<input type="checkbox"/> Transportation tie-down option	<input type="checkbox"/> to provide crash tested tie down brackets	
Elevator on Mobility Base <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter	<input type="checkbox"/> increase Indep in transfers <input type="checkbox"/> increase Indep in ADLs	<input type="checkbox"/> raise height for communication at standing level <input type="checkbox"/>
Push handles <input type="checkbox"/> extended <input type="checkbox"/> angle adjustable <input type="checkbox"/> standard	<input type="checkbox"/> caregiver access <input type="checkbox"/> caregiver assist	<input type="checkbox"/> allows "hooking" to enable increased ability to perform ADLs or maintain balance
<input type="checkbox"/> Lighter weight required	<input type="checkbox"/> self propulsion <input type="checkbox"/> lifting	<input type="checkbox"/>
<input type="checkbox"/> Heavy Duty required	<input type="checkbox"/> user weight greater than 250 pounds <input type="checkbox"/> extreme tone <input type="checkbox"/> over active movement	<input type="checkbox"/> broken frame on previous chair <input type="checkbox"/> multiple seat functions <input type="checkbox"/>
<input type="checkbox"/> Specific seat height required Floor to seat height	<input type="checkbox"/> foot propulsion <input type="checkbox"/> transfers <input type="checkbox"/> accommodation of leg length	<input type="checkbox"/> access to table or desk top <input type="checkbox"/>

Patient Name:

MOBILITY BASE	JUSTIFICATION	
<p>Rear wheel placement/Axle adjustability <input type="checkbox"/>None <input type="checkbox"/>semi adjustable <input type="checkbox"/>fully adjustable</p>	<input type="checkbox"/> improved UE access to wheels <input type="checkbox"/> improved stability <input type="checkbox"/> changing angle in space for improvement of postural stability	<input type="checkbox"/> 1-arm drive access <input type="checkbox"/> amputee placement <input type="checkbox"/>
<p>Angle Adjustable Back</p>	<input type="checkbox"/> postural control <input type="checkbox"/> control of tone/spasticity <input type="checkbox"/> accommodation of range of motion	<input type="checkbox"/> UE functional control <input type="checkbox"/> accommodation for seating system <input type="checkbox"/>
<p>POWER WHEELCHAIR CONTROLS <input type="checkbox"/>Proportional Type Body Parts Left Right <input type="checkbox"/>Non-Proportional/switches Type Body Parts Upgraded Electronics <input type="checkbox"/> <input type="checkbox"/>Display box <input type="checkbox"/>Digital interface electronics <input type="checkbox"/>ASL Head Array <input type="checkbox"/>Sip and puff tubing kit <input type="checkbox"/>Upgraded tracking electronics <input type="checkbox"/>Safety Reset Switches <input type="checkbox"/>Single or Multiple Actuator Control Module</p>	<input type="checkbox"/> provides access for controlling wheelchair <input type="checkbox"/> lacks motor control to operate proportional drive control <input type="checkbox"/> unable to understand proportional controls <input type="checkbox"/> programming for accurate control <input type="checkbox"/> progressive Disease/changing condition <input type="checkbox"/> Needed in order to operate power/tilt through joystick control <input type="checkbox"/> Allows user to see in which mode and drive the wheelchair is set; necessary for alternate controls <input type="checkbox"/> Allows w/c to operate when using alternative drive controls <input type="checkbox"/> Allows client to operate wheelchair through switches placed in tri-panel headrest <input type="checkbox"/> needed to operate sip and puff drive controls <input type="checkbox"/> increase safety when driving <input type="checkbox"/> correct tracking when on uneven surfaces <input type="checkbox"/> Used to change modes and stop the wheelchair when driving in latch mode <input type="checkbox"/> Allow the client to operate the power seat function(s) through the joystick control	<p>If Expandable Controller Recommended Provide Additional Narrative In Space At End Of Form re Why Patient Requires Expandable Controller vs. Non –Expandable Controller</p> <input type="checkbox"/> non-proportional drive control needed (Explain)

Patient Name:

MOBILITY BASE	JUSTIFICATION	
<input type="checkbox"/> Mount for switches or joystick	<input type="checkbox"/> attaches switches to w/c <input type="checkbox"/> Swing away for access or transfers	<input type="checkbox"/> midline for optimal placement <input type="checkbox"/> provides for consistent access
Attendant controlled joystick plus mount	<input type="checkbox"/> safety <input type="checkbox"/> long distance driving <input type="checkbox"/> operation of seat functions	<input type="checkbox"/> compliance with transportation regulations <input type="checkbox"/>
Battery	<input type="checkbox"/> power motor on wheelchair	
Charger	<input type="checkbox"/> charge battery for wheelchair	
Push rim active assist	<input type="checkbox"/> enable propulsion of manual wheelchair on sloped terrain	<input type="checkbox"/> enable propulsion of manual wheelchair for distance
Hangers/ Leg rests <input type="checkbox"/> 60 <input type="checkbox"/> 70 <input type="checkbox"/> 90 <input type="checkbox"/> elevating <input type="checkbox"/> heavy duty <input type="checkbox"/> articulating <input type="checkbox"/> fixed <input type="checkbox"/> lift off <input type="checkbox"/> swing away <input type="checkbox"/> rotational hanger brackets <input type="checkbox"/> adjustable knee angle <input type="checkbox"/> adjustable calf panel <input type="checkbox"/> Longer extension tube	<input type="checkbox"/> provide LE support <input type="checkbox"/> accommodate to hamstring tightness <input type="checkbox"/> elevate legs during recline <input type="checkbox"/> provide change in position for Les <input type="checkbox"/> maintain placement of feet on footplate	<input type="checkbox"/> durability <input type="checkbox"/> enable transfers <input type="checkbox"/> decrease edema <input type="checkbox"/> Accommodate lower leg length <input type="checkbox"/>
Foot support <input type="checkbox"/> adjustable Footplate <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> flip up <input type="checkbox"/> depth/angle adjustable	<input type="checkbox"/> provide foot support <input type="checkbox"/> accommodate to ankle ROM <input type="checkbox"/> allow foot to go under wheelchair base	<input type="checkbox"/> transfers <input type="checkbox"/>
Armrests <input type="checkbox"/> fixed <input type="checkbox"/> adjustable height <input type="checkbox"/> removable <input type="checkbox"/> swing away <input type="checkbox"/> flip back <input type="checkbox"/> reclining <input type="checkbox"/> full length pads <input type="checkbox"/> desk <input type="checkbox"/> pads tubular	<input type="checkbox"/> provide support with elbow at 90 <input type="checkbox"/> provide support for w/c tray <input type="checkbox"/> change of height/angles for variable activities	<input type="checkbox"/> remove for transfers <input type="checkbox"/> allow to come closer to table top <input type="checkbox"/> remove for access to tables <input type="checkbox"/>
Side guards	<input type="checkbox"/> prevent clothing getting caught in wheel or becoming soiled	
Wheel size: Wheel Style <input type="checkbox"/> mag <input type="checkbox"/> spokes <input type="checkbox"/>	<input type="checkbox"/> increase access to wheel <input type="checkbox"/> allow for seating system to fit on base	<input type="checkbox"/> increase propulsion ability <input type="checkbox"/> maintenance <input type="checkbox"/>
Quick Release Wheels	<input type="checkbox"/> allows wheels to be removed to decrease width of w/c for storage	<input type="checkbox"/> decrease weight for lifting <input type="checkbox"/>
Wheel rims/ hand rims <input type="checkbox"/> metal <input type="checkbox"/> plastic coated <input type="checkbox"/> vertical projections <input type="checkbox"/> oblique projections	<input type="checkbox"/> provide ability to propel manual wheelchair	<input type="checkbox"/> increase self-propulsion with hand weakness/decreased grasp
Tires: <input type="checkbox"/> pneumatic <input type="checkbox"/> flat free inserts <input type="checkbox"/> solid	<input type="checkbox"/> decrease maintenance <input type="checkbox"/> prevent frequent flats <input type="checkbox"/> increase shock absorbency	<input type="checkbox"/> decrease pain from road shock <input type="checkbox"/> decrease spasms from road shock <input type="checkbox"/>
Caster housing: Caster size: Style:	<input type="checkbox"/> maneuverability <input type="checkbox"/> stability of wheelchair <input type="checkbox"/> increase shock absorbency <input type="checkbox"/> durability <input type="checkbox"/> maintenance <input type="checkbox"/> angle adjustment for posture	<input type="checkbox"/> decrease pain from road shock <input type="checkbox"/> decrease spasms from road shock <input type="checkbox"/> allow for feet to come under wheelchair base <input type="checkbox"/> allows change in seat to floor height <input type="checkbox"/>
Shock absorbers	<input type="checkbox"/> decrease vibration	<input type="checkbox"/> provide smoother ride over rough terrain
Spoke Protector	<input type="checkbox"/> prevent hands from getting caught in spokes	<input type="checkbox"/>

Patient Name:

One armed device <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> enable propulsion of manual wheelchair with one arm	<input type="checkbox"/>
Anti-tippers	<input type="checkbox"/> prevent wheelchair from tipping backward	<input type="checkbox"/>
Amputee adapter	<input type="checkbox"/> provide support for stump/residual extremity	
<input type="checkbox"/> Crutch/cane holder <input type="checkbox"/> Oxygen Cylinder holder <input type="checkbox"/> IV hanger	<input type="checkbox"/> stabilize accessory on wheelchair	
Brake/wheel lock extension <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> increase indep in applying wheel locks
Other:		
Other:		

SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manuf/mod/size	Justification	
Seat Cushion		<input type="checkbox"/> accommodate impaired sensation <input type="checkbox"/> decubitus ulcers present <input type="checkbox"/> prevent pelvic extension <input type="checkbox"/> low maintenance	<input type="checkbox"/> stabilize pelvis <input type="checkbox"/> accommodate obliquity <input type="checkbox"/> accommodate multiple deformity <input type="checkbox"/> neutralize LE <input type="checkbox"/> increase pressure distribution <input type="checkbox"/>
Seat Wedge		<input type="checkbox"/> accommodate ROM	<input type="checkbox"/> Provide increased aggressiveness of seat shape to decrease sliding down in the seat
Cover Replacement		<input type="checkbox"/> protect back or seat cushion	<input type="checkbox"/>
Mounting hardware lateral trunk supports headrest medial thigh support back seat	fixed swing away for:	<input type="checkbox"/> attach seat platform/cushion to w/c frame <input type="checkbox"/> attach back cushion to w/c frame	<input type="checkbox"/> mount headrest <input type="checkbox"/> swing medial thigh support away <input type="checkbox"/> swing lateral supports away for transfers
Seat Board Back Board		<input type="checkbox"/> support cushion to prevent hammocking	<input type="checkbox"/> allows attachment of cushion to mobility base
Back		<input type="checkbox"/> provide lateral trunk support <input type="checkbox"/> accommodate deformity <input type="checkbox"/> accommodate or decrease tone <input type="checkbox"/> facilitate tone	<input type="checkbox"/> provide posterior trunk support <input type="checkbox"/> provide lumbar/sacral support <input type="checkbox"/> support trunk in midline <input type="checkbox"/>
Lateral pelvic/thigh support		<input type="checkbox"/> pelvis in neutral <input type="checkbox"/> accommodate pelvis <input type="checkbox"/> position upper legs	<input type="checkbox"/> accommodate tone <input type="checkbox"/> removable for transfers <input type="checkbox"/>
Medial Knee Support		<input type="checkbox"/> decrease adduction <input type="checkbox"/> accommodate ROM	<input type="checkbox"/> remove for transfers <input type="checkbox"/> alignment
Foot Support		<input type="checkbox"/> position foot <input type="checkbox"/> accommodate deformity	<input type="checkbox"/> stability <input type="checkbox"/> decrease tone <input type="checkbox"/> control position
Ankle strap/heel loops		<input type="checkbox"/> support foot on foot support <input type="checkbox"/> decrease extraneous	<input type="checkbox"/> provide input to heel <input type="checkbox"/> protect foot

Patient Name:

		movement	
Lateral trunk Supports	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> decrease lateral trunk leaning <input type="checkbox"/> accom asymmetry <input type="checkbox"/> contour for increased contact	<input type="checkbox"/> safety <input type="checkbox"/> control of tone <input type="checkbox"/>
Anterior chest strap, vest, or shoulder retractors		<input type="checkbox"/> decrease forward movement of shoulder <input type="checkbox"/> accommodation of TLSO decrease forward movement of trunk	<input type="checkbox"/> added abdominal support <input type="checkbox"/> alignment <input type="checkbox"/> assistance with shoulder control <input type="checkbox"/> decrease shoulder elevation <input type="checkbox"/>
Headrest		<input type="checkbox"/> provide posterior head support <input type="checkbox"/> provide posterior neck support <input type="checkbox"/> provide lateral head support <input type="checkbox"/> provide anterior head support <input type="checkbox"/> support during tilt and recline <input type="checkbox"/> improve feeding	<input type="checkbox"/> improve respiration <input type="checkbox"/> placement of switches <input type="checkbox"/> safety <input type="checkbox"/> accommodate ROM <input type="checkbox"/> accommodate tone <input type="checkbox"/> improve visual orientation
Neck Support		<input type="checkbox"/> decrease neck rotation	<input type="checkbox"/> decrease forward neck flexion
Upper Extremity Support Arm trough Posterior hand support ½ tray full tray swivel mount	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> decrease edema <input type="checkbox"/> decrease subluxation <input type="checkbox"/> control tone <input type="checkbox"/> provide work surface <input type="checkbox"/> placement for AAC/Computer/EADL	<input type="checkbox"/> decrease gravitational pull on shoulders <input type="checkbox"/> provide midline positioning <input type="checkbox"/> provide support to increase UE function <input type="checkbox"/> provide hand support in natural position
Pelvic Positioner Belt SubASIS bar Dual Pull		<input type="checkbox"/> stabilize tone <input type="checkbox"/> decrease falling out of chair/ **will not decrease potential for sliding due to pelvic tilting <input type="checkbox"/> prevent excessive rotation	<input type="checkbox"/> pad for protection over boney prominence <input type="checkbox"/> prominence comfort <input type="checkbox"/> special pull angle to control rotation <input type="checkbox"/>
Bag or pouch		Holds: <input type="checkbox"/> medicines <input type="checkbox"/> special food <input type="checkbox"/> orthotics <input type="checkbox"/> clothing changes	<input type="checkbox"/> diapers <input type="checkbox"/> catheter/hygiene <input type="checkbox"/> ostomy supplies <input type="checkbox"/>
Other			

ADDITIONAL NARRATIVE DOCUMENTATION (MUST BE LEGIBLE)
