



Wheelchair and Seating Evaluation and Justification

| | |
|-------------|------|
| Name: | |
| Date: | |
| MR #: | |
| Account #: | |
| Birth Date: | Sex: |
| Physician: | |

PATIENT INFORMATION:

| | | | | |
|--|------------------------------|------|---|-------|
| Name: | DOB: | Sex: | Date seen: | Time: |
| Address: | Physician: | | <i>This evaluation/justification form will serve as the LMN for the following suppliers:</i> | |
| | Seating Therapist: Phone: | | | |
| Phone: | Primary Therapist: | | Supplier: Contact Person: Phone: <input type="checkbox"/> Rehabilitation Engineering Program or 2 nd supplier Contact Person: Phone : | |
| Spouse/Parent/Caregiver name: | Insurance/Payer: | | | |
| Phone number: | Recipient # | | | |
| Reason for Referral | | | | |
| Patient Goals: | | | | |
| Caregiver goals and specific limitations that may effect care: | | | | |

MEDICAL HISTORY:

| | | | | | |
|---|-------------------------------------|---|--------|------------|------------|
| Diagnosis: | ICD9 Code: | Primary Diagnosis: | Onset: | ICD9 Code: | Diagnosis: |
| | ICD9 Code: | Diagnosis: | | ICD9 Code: | Diagnosis: |
| <input type="checkbox"/> Progressive Disease | Relevant past and future surgeries: | | | | |
| Height: | Weight: | Explain recent changes or trends in weight: | | | |
| History: | | | | | |
| Cardio Status: | | Functional Limitations: | | | |
| <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> NA | | | | | |
| Respiratory Status: | | Functional Limitations: | | | |
| <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> NA | | | | | |
| Orthotics: | | | | | |

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 | Hours with caregiver: |
| <input type="checkbox"/> Home is accessible to patient | Storage of Wheelchair: <input type="checkbox"/> In home <input type="checkbox"/> other |
| Comments: | |

Name:

RIC MR#:

Insurance/recipient #

COMMUNITY ADL:

TRANSPORTATION:

Car Van Public Transportation Adapted w/c Lift Ambulance Other: Sits in wheelchair during transport

Where is w/c stored during transport? Tie Downs

Self Driver Drive while in Wheelchair yes no

Employment:

Specific requirements pertaining to mobility

School:

Specific requirements pertaining to mobility

Other:

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: Right Left NA Comments:

Functional Processing Skills for Wheeled Mobility

Processing Skills are adequate for safe wheelchair operation

Comments:

COMMUNICATION:

Verbal Communication WFL receptive WFL expressive Understandable Difficult to understand non-communicative

Uses an augmentative communication device Manufacturer/Model :

AAC Mount Needed:

SENSATION and SKIN ISSUES:

Sensation

Intact Impaired Absent
 Hyposensate Hypersensate
 Defensiveness

Level of sensation:

Pressure Relief:

Able to perform effective pressure relief : Yes No

Method:

If not, Why?:

Skin Issues/Skin Integrity

Current Skin Issues Yes No
 Intact Red area Open Area
 Scar Tissue At risk from prolonged sitting
Where _____

History of Skin Issues Yes No

Where _____

When _____

Hx of skin flap surgeries Yes No

Where _____

When _____

Complaint of Pain: Please describe

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: |

Name:

RIC MR#:

Insurance/recipient #

CURRENT SEATING / MOBILITY:

Current Mobility Base: None Dependent Dependent with Tilt Manual Scooter Power Type of Control:

Manufacturer: Model: Serial #:

Size: 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 | |

When relevant: Overall seat height Overall w/c length Overall w/c width

Describe posture in present seating system:

WHEELCHAIR SKILLS:

| | 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:

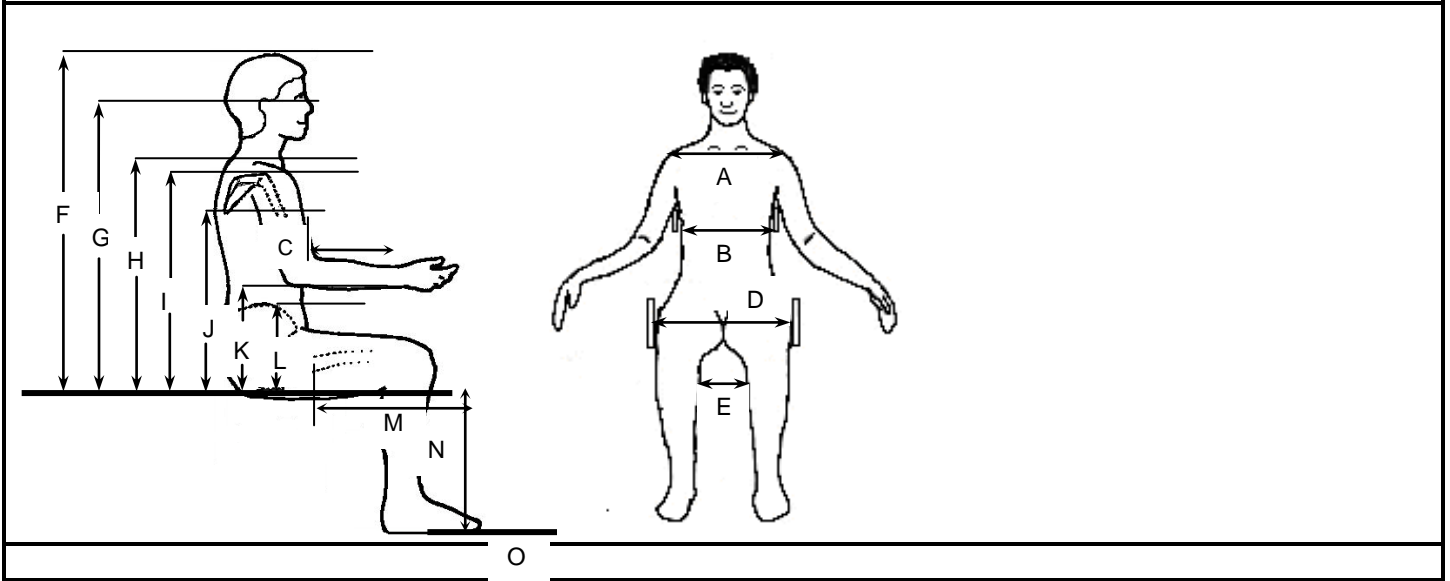
| Balance | | Transfers | Ambulation |
|---|-------------------------------------|--|---|
| Sitting Balance: | Standing Balance | <input type="checkbox"/> Independent | <input type="checkbox"/> Independent |
| <input type="checkbox"/> WFL | <input type="checkbox"/> WFL | <input type="checkbox"/> Min Assist | <input type="checkbox"/> 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"/> Ambulates with Device |
| <input type="checkbox"/> Min Assist | <input type="checkbox"/> Mod 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"/> Unable to Ambulate |
| <input type="checkbox"/> Max Assist | <input type="checkbox"/> Unable | <input type="checkbox"/> Sliding Board | |
| <input type="checkbox"/> Unable | | <input type="checkbox"/> Lift / Sling Required | |
| Comments: | | | |

Name:

RIC MR#:

Insurance/recipient #

MAT EVALUATION:



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

Additional Comments:




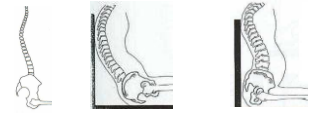




Hamstring flexibility: Pelvis to thigh angle accommodate greater than 90 Thigh to calf angle accommodate less than 90

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

Name:

RIC MR#:

Insurance/recipient #

| POSTURE: | | | COMMENTS: | |
|--|---|---|--|--|
| PELVIS | <p>Anterior / Posterior</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible</p> | <p>Obliquity</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> L elev</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible</p> | <p>Rotation-Pelvis</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> Right Anterior <input type="checkbox"/> Left Anterior</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible</p> | |
| | <p>TRUNK</p> <p>Anterior / Posterior</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic Kyphosis <input type="checkbox"/> ↑ Lumbar Lordosis</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other</p> | <p>Left Right</p>  <p><input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right</p> <p><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</p> | <p>Rotation-shoulders and upper trunk</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> Left-anterior <input type="checkbox"/> Right-anterior</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other</p> | |
| <p>Describe LE Neurological Influence/Tone:</p> | | | | |
| HIPS | <p>Position</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible</p> | <p>Windswept</p>  <p><input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p><input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible</p> | <p>Hip Flexion/Extension Limitations:</p> <p>Hip Internal/External Range of motion Limitations:</p> | |
| | <p>KNEES & FEET</p> <p>Knee R.O.M.</p> <p>Left Right</p> <p><input type="checkbox"/> WFL <input type="checkbox"/> WFL</p> <p><input type="checkbox"/> Limitations <input type="checkbox"/> Limitations</p> | | <p>Foot Positioning</p> <p><input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>ROM concerns:</p> <p>Dorsi-Flexed <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Plantar Flexed <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Inversion <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Eversion <input type="checkbox"/> L <input type="checkbox"/> R</p> | |

Name:

RIC MR#:

Insurance/recipient #

| 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: Describe Tone/Movement of UE: | | | | |
| | Upper Extremity | SHOULDERS <table border="0"> <tr> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> </tr> <tr> <td> <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed </td> <td> <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed </td> </tr> </table> | | Left | Right | <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed | <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed |
| Left | Right | | | | | | |
| <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed | <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed | | | | | | |
| | ELBOWS <table border="0"> <tr> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> </tr> </table> | Left | Right | R.O.M. Strength concerns: | | | |
| Left | Right | | | | | | |
| WRIST & HAND | <table border="0"> <tr> <td style="text-align: center;">Left</td> <td style="text-align: center;">Right</td> </tr> <tr> <td><input type="checkbox"/> Fisting</td> <td></td> </tr> </table> | Left | Right | <input type="checkbox"/> Fisting | | Strength / Dexterity: | |
| Left | Right | | | | | | |
| <input type="checkbox"/> Fisting | | | | | | | |

| |
|---|
| Goals for Wheelchair Mobility <input type="checkbox"/> Independence with mobility in the home and motor related ADLs (MRADLs) in the community <input type="checkbox"/> Independence with MRADLs in the community <input type="checkbox"/> Provide dependent mobility <input type="checkbox"/> Provide recline <input type="checkbox"/> Provide tilt <input type="checkbox"/> |
| Goals for Seating system <input type="checkbox"/> Optimize pressure distribution <input type="checkbox"/> Provide support needed to facilitate function or safety <input type="checkbox"/> Provide corrective forces to assist with maintaining or improving posture <input type="checkbox"/> Accommodate client's posture: current seated postures and positions are not flexible or will not tolerate corrective forces <input type="checkbox"/> Client to be independent with relieving pressure in the wheelchair <input type="checkbox"/> Enhance physiological function such as breathing, swallowing, digestion |
| Simulation ideas: Equipment trials: State why other equipment was unsuccessful: |

Name:

RIC MR#:

Insurance/recipient #

MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION

| MOBILITY BASE | JUSTIFICATION | |
|---|---|--|
| Manufacturer: Model: Color: Size: 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 |
| 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"/> |
| 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"/> |
| Rear wheel placement/Axle adjustability <input type="checkbox"/> None <input type="checkbox"/> semi adjustable <input type="checkbox"/> fully adjustable | <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"/> |

Name:

RIC MR#:

Insurance/recipient #

| MOBILITY BASE | JUSTIFICATION | |
|---|--|---|
| Angle Adjustable Back | <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"/> |
| POWER WHEELCHAIR CONTROLS <input type="checkbox"/> Proportional Type Body Parts <input type="checkbox"/> Left <input type="checkbox"/> 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 | <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 | <input type="checkbox"/> non-proportional drive control needed |
| <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"/> |

Name:

RIC MR#:

Insurance/recipient #

| | | |
|--|---|---|
| Battery | <input type="checkbox"/> power motor on wheelchair | |
| MOBILITY BASE | JUSTIFICATION | |
| 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"/> |
| 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"/> Cylinder holder | <input type="checkbox"/> Stabilize accessory on wheelchair | |

Name:

RIC MR#:

Insurance/recipient #

| | | |
|--|--|---|
| <input type="checkbox"/> IV hanger | | |
| 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 <input type="checkbox"/> lateral trunk supports <input type="checkbox"/> headrest <input type="checkbox"/> medial thigh support <input type="checkbox"/> back <input type="checkbox"/> seat | <input type="checkbox"/> fixed <input type="checkbox"/> 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 |
| <input type="checkbox"/> Seat Board <input type="checkbox"/> 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 movement | <input type="checkbox"/> provide input to heel <input type="checkbox"/> protect foot |
| Lateral trunk Supports | <input type="checkbox"/> R <input type="checkbox"/> L | <input type="checkbox"/> decrease lateral trunk leaning <input type="checkbox"/> accommodate 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"/> |

Name:

RIC MR#:

Insurance/recipient #

| Component | Manuf/mod/size | Justification | |
|--|---|---|---|
| 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 <input type="checkbox"/> Arm trough <input type="checkbox"/> Posterior hand support <input type="checkbox"/> ½ tray <input type="checkbox"/> full tray <input type="checkbox"/> 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 <input type="checkbox"/> Belt <input type="checkbox"/> SubASIS bar <input type="checkbox"/> 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 | | | |
| | | | |
| | | | |

--The above equipment has a life- long use expectancy. Growth and changes in medical and/or functional conditions would be the exceptions.

| | | |
|--|--|--------------|
| Patient/Client/Caregiver Signature: | | Date: |
| Therapist Name Printed: | | |
| Therapist's Signature | | Date: |
| Supplier's Name Printed: | | |
| Supplier's Signature: | | Date: |

I agree with the above findings and recommendations of the therapist and supplier:

| | | |
|----------------------------------|--|--------------|
| Physician's Name Printed: | | |
| Physician's Signature: | | Date: |