

MEDICAL CLEARANCE FORM

PHYSICAL ASSESSMENT FOR STANDING EQUIPMENT

Section A: Patient information							
Patient name R	Recipient identification number						
Diagnosis							
Onset date of disability	Date of birth						
Current weight	Current height _						
Section B: Physician Information							
Provider's name	Provider number						
Section C: General Physical Status							
*Please circle most appropriate answer. If abnormal or progress is circled, please explain in the space provided.							
Cardiopulmonary status	Normal	Abnormal	Progress				
Sensation/body awareness	Normal	Abnormal	Progress				
•			-				
Skin status	Normal	Abnormal	Progress				
Skin Status	TOTHER	110110111141	11081655				
Supertion states	NI 1	A 1 1	D				
Sensation status	Normal	Abnormal	Progress				
Muscle strength status (Specify upper and lower stre	ength) Normal	Abnormal	Progress				
Muscle tone status	Normal	Abnormal	Progress				
ROM status (Specify upper and lower ROM)	WFL (within functional lin	nits) Abnorma	l Progress				
,		,	- 6				
Standing static and dynamic balance	Normal	Abnormal	Progress				
Standing static and dynamic varance	Nominal	Aunoman	11051633				
Sitting static and dynamic balance	Normal	Abnormal	Progress				

	equires Assistance Wilease circle most appropria		ing			
Ambulation	Independent	Minimum	Maximum	Dependent		
Transfers	Independent	Minimum	Maximum	Dependent		
Propelling wheelchair	Independent	Minimum	Maximum	Dependent		
Sitting	Independent	Minimum	Maximum	Dependent		
Feeding	Independent	Minimum	Maximum	Dependent		
Dressing	Independent	Minimum	Maximum	Dependent		
Hygiene	Independent	Minimum	Maximum	Dependent		
• •	ection E: Rational Fo			1 1 1		
~	*Please circle yes or n					
To maintain bone integrity and increase bo	one density		Yes	No		
To improve circulation in the lower extrem						
o improve range of motion				No		
To decrease muscle spasms	•					
To strengthen cardiovascular system and build endurance				No		
To improve strength to the trunk and lower extremities				No		
To prevent or decrease joint muscle contra			Yes	No		
To lessen or prevent progressive scoliosis				No		
To aid normal skeletal development			Yes	No		
	ion F: Special Consid	lerations		1		
* Please circle the correct answer or fill in the blanks						
What is the height range and weight capac	eity of the stander requ	ested?				
Height range from to	Weight ca	pacity from	to			
Additional Comments:						
What are the position needs?	Sup	ine Vertical	Prone N	Aulti-positional		
Additional Comments:	Sup	ine vertical	110ne iv	ruiti positionui		
raditional comments.						
What is the cost of the stander?						
Please individually list each requested acc	essory and its cost.					
TI 1 314 4 1 1 1 10	N.C. (1	3 7	1.0	,·		
How long will the stander be required?	Months	Years	Life	time		
Additional Comments:						
Is the nonpaid primary caregiver willing a	nd able to be trained to	use the equipn	nent safely?	Yes No		
Additional Comments:						
Assessment Completed By:		Da	te:			
	G: Physician's Signat	ure and Date				
I certify the medical necessity of these iter				ned patient and		
to my knowledge there are no medical or surgical contraindications for the use of a stander.						
Physician's signature:	Physician's signature: Date:					