

Seating/Mobility Evaluation

PATIENT INFORMATION:

Name:	Date seen:	DOB:	Sex:
Address:	Physician:	Phone:	
	Seating Therapist:	Phone:	
Phone:	Primary Therapist:	Phone:	
Referred by: (If other than MD)	Equipment Supplier Company:	Caregiver name:	
Insurance/Payor: Recipient#:	Contact person: Phone:	Phone number:	
Reason for Referral			
Patient Goals:			
Caregiver goals and specific limitations that may effect care:			

MEDICAL HISTORY:

Diagnosis:	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:
	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:
	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:
<input type="checkbox"/> Progressive Disease	<input type="checkbox"/> Osteoporosis	Recent/future surgeries/prognosis:		
Height:	Weight:	Explain recent changes or trends in weight:		
History: _____				
Cardio Status:		Functional Limitations:		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired				
Respiratory Status:		Functional Limitations:		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired				
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 without caregiver:	
Entrance:	<input type="checkbox"/> Level <input type="checkbox"/> Stairs <input type="checkbox"/> Ramp <input type="checkbox"/> Lift	Width of entrance:	Number of floors:
<input type="checkbox"/> Accessible Bedroom <input type="checkbox"/> Accessible Bathroom		Narrowest Doorway to access:	
Non-accessible rooms:			
Storage of Wheelchair:			

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COMMUNITY ADL:

TRANSPORTATION: Car Van Bus Adapted w/c Lift Ambulance Other:

Where is w/c stored during transport? _____ Size of area needed for transport of w/c w x d x h: _____

Self Driver Drive while in Wheelchair yes no Tie Downs: _____

Van head clearance: Door " Inside " Van door width " Ramp lift w " x d "

#Hours per day/specific requirements pertaining to mobility _____

Employment: _____

#Hours per day/specific requirements pertaining to mobility _____

School: _____

Other _____

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: Right Left Comments: _____

Functional Processing Skills for Wheeled Mobility

Processing Skills are adequate for safe wheelchair operation

Areas of concern that may interfere with safe operation of wheelchair	Description or problem/Plan to ensure safety
<input type="checkbox"/> Attention to environment	
<input type="checkbox"/> Judgment	
<input type="checkbox"/> Vision or visual processing	
<input type="checkbox"/> Hearing	
<input type="checkbox"/> Motor Planning	
<input type="checkbox"/> Fluctuations in Behavior	

COMMUNICATION:

Verbal Communication WNL Understandable Difficult to understand non-communicative

Uses an augmentative communication device Manufacturer/Model : _____

Equipment needs/ Mounting : _____

SENSATION and SKIN ISSUES:

Sensation <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent Level of sensation: _____	Sensory Tactile Processing <input type="checkbox"/> Hyposensate <input type="checkbox"/> Hypersensate <input type="checkbox"/> Defensiveness <u>Complaint of Pain: Please describe</u>
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 _____	
Comments: _____	

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 Mngmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter						Comments:

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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:		Model:	
Size:		Color:	
		Serial #:	
		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			
Describe Posture in present seating system:			

WHEELCHAIR SKILLS:

	Indep	Assist	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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	One arm: <input type="checkbox"/> left <input type="checkbox"/> right One foot: <input type="checkbox"/> left <input type="checkbox"/> right <input type="checkbox"/> Both Feet <input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance:
Operate Scooter	<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: Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c: w/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to perform Weight Shifts/Pressure Relief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Method:
Bed Confined without w/c	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hours spent sitting in w/c each day:		
Does Mobility Meet Functional Requirement? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Activity Tolerance/Endurance:					
Additional Comments:					

Name:

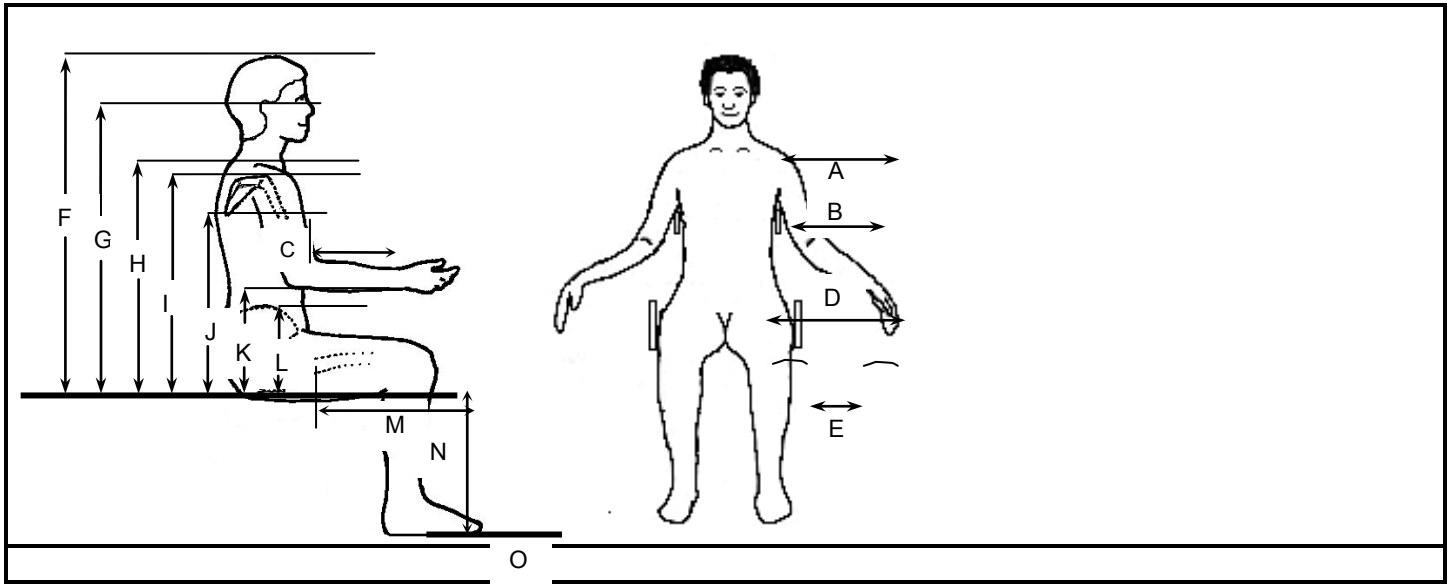
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MOBILITY/BALANCE:

Balance	Transfers	Ambulation
Sitting Balance:	Standing Balance	
<input type="checkbox"/> WFL <input type="checkbox"/> Uses UE for support	<input type="checkbox"/> WFL	<input type="checkbox"/> Independent
<input type="checkbox"/> Min Support	<input type="checkbox"/> Min Support	<input type="checkbox"/> Min Assist
<input type="checkbox"/> Mod Support	<input type="checkbox"/> Mod Support	<input type="checkbox"/> Max Asst
<input type="checkbox"/> Unable	<input type="checkbox"/> Unable	<input type="checkbox"/> Sliding Board
		<input type="checkbox"/> Lift / Sling Required
Comments:		

MAT EVALUATION:



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

Additional Comments:




** Asymmetrical Width: i.e., windswept or Scoliotic posture; widest point to widest point

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

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	POSTURE/TONE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
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:	
EXTREMITY	SHOULDERS Left Right <input type="checkbox"/> Functional <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract <input type="checkbox"/> pro-retract <input type="checkbox"/> subluxed <input type="checkbox"/> subluxed	R.O.M. <input type="checkbox"/> WNL <input type="checkbox"/> WFL Limitations: Strength concerns:	Describe Tone/Movement of UE:	
	ELBOWS Left Right	R.O.M. Strength concerns:		
WRIST & HAND	Left Right <input type="checkbox"/> Fisting	Strength / Dexterity:		
TRUNK	Anterior / Posterior  <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	Left Right  Degree of curvature: _____ ° <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	Rotation-shoulders and upper trunk  <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	

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	POSTURE/TONE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
P E L V I S	Anterior / Posterior  <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	Obliquity  <input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> I elev <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	Rotation-Pelvis  <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	
	H I P S	Position  <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	Windswept  <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	Range of Motion  Left Right WNL Adequate for sitting Limitations
KNEES & FEET	Knee R.O.M. Left Right <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Limitations <input type="checkbox"/> Limitations	Strength concerns: Knee/Hamstring positioning needs:	Foot Positioning <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	Foot Positioning Needs:

Goals for Mobility Base
Goals for Seating system
Simulation Ideas/Equipment trials/ State why other equipment was unsuccessful:

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MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION

MOBILITY BASE	JUSTIFICATION
General Info <input type="checkbox"/> Dependent <input type="checkbox"/> Manual <input type="checkbox"/> Power <input type="checkbox"/> Scooter Power Control <input type="checkbox"/> R <input type="checkbox"/> L Other: _____ Color: _____	See specifics below
Manufacturer: Model: Size: Width Seat Depth Back Height Seat to Back Height	<input type="checkbox"/> provide transport from point A to B <input type="checkbox"/> promote Indep mobility <input type="checkbox"/> is not a safe, functional ambulatory <input type="checkbox"/>
Stroller Base	<input type="checkbox"/> infant child <input type="checkbox"/> non-functional ambulatory <input type="checkbox"/> unable to propel manual wheelchair <input type="checkbox"/> <input type="checkbox"/> allows for growth
Manual Mobility Base <input type="checkbox"/> K0004 <input type="checkbox"/> K0005 <input type="checkbox"/> K0006 <input type="checkbox"/> E1235 <input type="checkbox"/> E1236 <input type="checkbox"/> E1237 <input type="checkbox"/> E1238	<input type="checkbox"/> non-functional ambulator <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"/> allows "hooking" to enable increased ability to perform ADLs or maintain balance <input type="checkbox"/> caregiver assist
Lighter weight required	<input type="checkbox"/> self propulsion <input type="checkbox"/> <input type="checkbox"/> lifting
Heavy Duty required	<input type="checkbox"/> user weight greater than 250 pounds <input type="checkbox"/> broken frame on previous chair <input type="checkbox"/> extreme tone <input type="checkbox"/> multiple seat functions <input type="checkbox"/> over active
Specific seat height required Floor to seat height	<input type="checkbox"/> foot propulsion <input type="checkbox"/> access to table or desk top <input type="checkbox"/> transfers <input type="checkbox"/> <input type="checkbox"/> accommodation of leg length
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"/> stability <input type="checkbox"/> improved stability <input type="checkbox"/> 1-arm drive access <input type="checkbox"/> changing angle in space for improvement with postural <input type="checkbox"/> amputee placement <input type="checkbox"/>
Angle Adjustable Back	<input type="checkbox"/> postural control <input type="checkbox"/> UE functional control <input type="checkbox"/> control of tone/spasticity <input type="checkbox"/> accommodation for seating system <input type="checkbox"/> accommodation of range of motion <input type="checkbox"/>
Tilt Base or added <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> E1161 <input type="checkbox"/> E1231 <input type="checkbox"/> E1232 <input type="checkbox"/> E1233 <input type="checkbox"/> E1234	<input type="checkbox"/> change position against gravitational force on head and shoulders <input type="checkbox"/> management of tone <input type="checkbox"/> change position for pressure relief/can not weight shift <input type="checkbox"/> rest periods <input type="checkbox"/> transfers <input type="checkbox"/> control edema <input type="checkbox"/> facilitate postural control <input type="checkbox"/>

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MOBILITY BASE	JUSTIFICATION	
Recline Base <input type="checkbox"/> E1125 <input type="checkbox"/> E1126	<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"/> head positioning	<input type="checkbox"/> rest periods <input type="checkbox"/> repositioning for transfers or clothing/diaper /catheter changes <input type="checkbox"/>
Elevator on Mobility Base	<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"/>
Scooter/POV <input type="checkbox"/> E1230	<input type="checkbox"/> can safely operate <input type="checkbox"/> can safely transfer	<input type="checkbox"/> has adequate trunk stability <input type="checkbox"/> can not propel manual wheelchair <input type="checkbox"/>
Power Mobility Base <input type="checkbox"/> K0010 <input type="checkbox"/> K0011 <input type="checkbox"/> K0012 <input type="checkbox"/> K0014 <input type="checkbox"/> E1239	<input type="checkbox"/> non-ambulatory <input type="checkbox"/> can not propel manual wheelchair	<input type="checkbox"/>
W/C controls Body Part _____ <input type="checkbox"/> Proportional <input type="checkbox"/> Non-Proportional/switches <input type="checkbox"/> Electronic <input type="checkbox"/> Mechanical Manufacturer/Model: <input type="checkbox"/> E2320 <input type="checkbox"/> E2321 <input type="checkbox"/> E2322 <input type="checkbox"/> E2323 <input type="checkbox"/> E2324 <input type="checkbox"/> E2325 <input type="checkbox"/> E23226 <input type="checkbox"/> E2327 <input type="checkbox"/> E2328 <input type="checkbox"/> E2329 <input type="checkbox"/> E2330 <input type="checkbox"/> E2331 <input type="checkbox"/> E2399	<input type="checkbox"/> provides access for controlling wheelchair <input type="checkbox"/> safety <input type="checkbox"/> EADL access	<input type="checkbox"/> computer access <input type="checkbox"/> power tilt or recline <input type="checkbox"/> programming for accurate control <input type="checkbox"/>
Hangers/ Leg rests <input type="checkbox"/> 70 <input type="checkbox"/> 90 <input type="checkbox"/> elevating <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"/> recessed calf panel <input type="checkbox"/> heavy duty <input type="checkbox"/> Other <input type="checkbox"/> E0990 <input type="checkbox"/> K0195 <input type="checkbox"/> K0053	<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"/> durability <input type="checkbox"/> enable transfers <input type="checkbox"/> decrease edema <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 adjustable <input type="checkbox"/> K0040 <input type="checkbox"/> K0041	<input type="checkbox"/> Support foot <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"/> K0106 <input type="checkbox"/> K0020 <input type="checkbox"/> E0873	<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"/>

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MOBILITY BASE	JUSTIFICATION	
Wheel size: 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 <input type="checkbox"/> decrease width of w/c for storage	<input type="checkbox"/> decrease weight for lifting <input type="checkbox"/>
Wheel rims/ hand rims <input type="checkbox"/> E0967 <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 for individual with hand weakness/decreased grasp	<input type="checkbox"/>
Tires: <input type="checkbox"/> pneumatic <input type="checkbox"/> flat free inserts <input type="checkbox"/> solid <input type="checkbox"/> K0093 <input type="checkbox"/> K0097	<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
Spoke Protector <input type="checkbox"/> K0065	<input type="checkbox"/> prevent hands from getting caught in spokes	<input type="checkbox"/>
Shock absorbers <input type="checkbox"/> E1016 <input type="checkbox"/> E1018	<input type="checkbox"/> decrease vibration <input type="checkbox"/>	<input type="checkbox"/> provide smoother ride over rough terrain
Push rim active assist <input type="checkbox"/> E0986	<input type="checkbox"/> enable propulsion of manual wheelchair on sloped terrain	<input type="checkbox"/> enable propulsion of manual wheelchair for distance <input type="checkbox"/>
One armed device <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> E0958	<input type="checkbox"/> enable propulsion of manual wheelchair with one arm	<input type="checkbox"/> unable to propel assisting with feet <input type="checkbox"/>
Anti-tippers <input type="checkbox"/> E0971	<input type="checkbox"/> prevent wheelchair from tipping backward	<input type="checkbox"/>
Battery <input type="checkbox"/> E2360 <input type="checkbox"/> E2361 <input type="checkbox"/> E2632 <input type="checkbox"/> E2363 <input type="checkbox"/> E2364 <input type="checkbox"/> E2365	<input type="checkbox"/> power motor on wheelchair	
Charger	<input type="checkbox"/> charge battery for wheelchair	
Attendant controlled joystick	<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"/>
Ventilator Tray <input type="checkbox"/> E0129 <input type="checkbox"/> E0130	<input type="checkbox"/> Stabilize ventilator on wheelchair	
Amputee adapter <input type="checkbox"/> E0959	<input type="checkbox"/> Provide support for stump/residual extremity	
<input type="checkbox"/> K0102 Crutch/cane holder <input type="checkbox"/> K0104 Cylinder holder <input type="checkbox"/> K0105 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

SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Equipment eval/justification form

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Component	Manufacturer	Model	Size	Justification
Seat Cushion <input type="checkbox"/> K0108 <input type="checkbox"/> K0669 <input type="checkbox"/> E2601 <input type="checkbox"/> E2602 <input type="checkbox"/> E2603 <input type="checkbox"/> E2604 <input type="checkbox"/> E2605 <input type="checkbox"/> E2606 <input type="checkbox"/> E2607 <input type="checkbox"/> E2608 <input type="checkbox"/> E2609 <input type="checkbox"/> K0659 <input type="checkbox"/> _____				<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"/> accommodate impaired sensation <input type="checkbox"/> decubitus ulcers present <input type="checkbox"/> prevent pelvic extension <input type="checkbox"/> low maintenance <input type="checkbox"/>
Cover Replacement <input type="checkbox"/> K0668				<input type="checkbox"/> protect back or seat cushion <input type="checkbox"/>
Seat Platform <input type="checkbox"/> E0992 <input type="checkbox"/> E2618				<input type="checkbox"/> support cushion to prevent hammocking <input type="checkbox"/>
Back <input type="checkbox"/> E2611 <input type="checkbox"/> E2612 <input type="checkbox"/> E2613 <input type="checkbox"/> E2614 <input type="checkbox"/> E2615 <input type="checkbox"/> E2616 <input type="checkbox"/> E2617 <input type="checkbox"/> E2620 <input type="checkbox"/> E2621 <input type="checkbox"/> E0956 <input type="checkbox"/> K0669				<input type="checkbox"/> provide posterior trunk support <input type="checkbox"/> provide lumbar/sacral support <input type="checkbox"/> support trunk in midline <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"/>
Additional pieces to seat or back cushion				
Mounting hardware <input type="checkbox"/> lateral trunk supports <input type="checkbox"/> headrest <input type="checkbox"/> medial thigh support <input type="checkbox"/> joystick	<input type="checkbox"/> fixed <input type="checkbox"/> swing away <input type="checkbox"/> E1028			<input type="checkbox"/> attach seat platform/cushion to w/c frame <input type="checkbox"/> attach back cushion to w/c frame <input type="checkbox"/> swing joystick out of the way <input type="checkbox"/> swing headrest away <input type="checkbox"/> swing medial thigh support away <input type="checkbox"/>
Lateral pelvis/thigh support <input type="checkbox"/> E0956				<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"/> E0957				<input type="checkbox"/> decrease adduction <input type="checkbox"/> accommodate ROM <input type="checkbox"/> remove for transfers <input type="checkbox"/> alignment <input type="checkbox"/>
Foot Support <input type="checkbox"/> K0040 <input type="checkbox"/> K0041				<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"/> E0951				<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 <input type="checkbox"/>

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Component	Manufacturer	Model	Size	Justification
Lateral trunk Supports <input type="checkbox"/> E0956			<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 or shoulder supports <input type="checkbox"/> E0960				<input type="checkbox"/> decrease forward movement of trunk <input type="checkbox"/> decrease forward movement of shoulders <input type="checkbox"/> decrease shoulder elevation <input type="checkbox"/> accommodation of TLSO <input type="checkbox"/> added abdominal support <input type="checkbox"/> alignment <input type="checkbox"/> assistance with shoulder control <input type="checkbox"/>
Headrest <input type="checkbox"/> E0955 <input type="checkbox"/> E0996 <input type="checkbox"/> K0108				<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 <input type="checkbox"/>
Neck Support <input type="checkbox"/> E0996 <input type="checkbox"/> K0108				<input type="checkbox"/> decrease forward neck flexion <input type="checkbox"/> decrease neck rotation
Upper Extremity Support <input type="checkbox"/> K0106 <input type="checkbox"/> K0107				<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"/> 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"/>
Pelvic Positioner <input type="checkbox"/> E0978 <input type="checkbox"/> K0108				<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"/>

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Insurance/Recipient#

Component	Manufacturer	Model	Size	Justification
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				

Patient/Client Name Printed:		
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:
Physician Address:		
Physician Phone:		