Clinical Information for Wheeled Mobility

PART A: PATIENT / PROVIDER INFORMATION - Please Print

Name: _____ Sponsor Soc. Sec. No: _____

Address:_____ City: _____ St: _____ Zip: _____

Phone: (_____) _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Date Referred: _____ Date of Eval: _____ Physician: _____

OT: _____ PT: _____

Referred By: _____

Reason for Referral: _____

_____

Patient Goals: _____

_____

Caregiver Goals: _____

_____

PART B: MEDICAL HISTORY

Dx:_____ ICD-9: _____ ICD-9: _____

_____ ICD-9: _____ ICD-9: _____

Hx / Progression: _____

_____

Recent / Planned Surgeries: _____

_____

Cardio-Respiratory Status: Intact Impaired

Comments: _____

_____

PART C: CURRENT SEATING / MOBILITY: (Type – Manufacturer – Model)

Chair: _____ Age: _____

w/c Cushion: _____ Age: _____ w/c Back: _____ Age: _____

Reason for: Replacement Repair Update _____

_____

Funding Source: _____

PART D: HOME ENVIRONMENT

House Apt Asst Living LTCF Alone w/ Family-Caregivers: _____

Entrance: Level Ramp Lift Stairs Entrance Width: _____

w/c Accessible Rooms: Yes No Narrowest Doorway Required to Access: _____

Comments: _____

_____

PART E: COMMUNITY ADL

TRANSPORTATION: Car Van Bus ADAPTED WITH: Chair Lift Ramp Ambulance Other*

Driving Requirements: _____

Employment / Educational Requirements: _____

*Other: _____

Continued

PART F: COGNITIVE / VISUAL STATUS (Please check appropriate box and make comments as needed)

	Intact	Impaired	Comments
Memory Skills			
Problem Solving			
Judgment			
Attention / Concentration			
Vision			
Hearing			
Other			

PART G: ADL STATUS (Please check appropriate box and make comments as needed)

	INDEP	ASSIST	UNABLE	Comments / Other AT Equipment Required
Dressing				
Bathing				
Feeding				
Grooming/Hygiene				
Toileting				
Meal Prep				
Home Management				
Bowel Management	Continent		Incontinent	
Bladder Management	Continent		Incontinent	

PART H: MOBILITY SKILLS (Please check appropriate box and make comments as needed)

	INDEP	ASSIST	UNABLE	N/A	COMMENTS
Bed ⟷ w/c Transfers					
w/c ⟷ Commode Transfers					
Ambulation					Device:
Manual w/c Propulsion					
Operate Power w/c w/ Std. Joystick					
Operate Power w/c w/ Alternative Controls					
Able to Perform Weight Shifts					Type:
Hours Spent Sitting in w/c Each Day:		Comments:			

PART I: SENSATION

	Intact	Impaired	Absent
Hx of Pressure Sores		Yes	No
Current Pressure Sores		Yes	No

Comments: _____

_____

_____

Continued

PART J: CLINICAL CRITERIA / ALGORITHM SUMMARY

	YES	NO	N/A
1. Is there a mobility limitation causing an inability to safely participate in one or more Mobility Related Activities of Daily Living in a reasonable time frame?			
Explain:			
2. Are there cognitive or sensory deficits (awareness / judgment / vision / etc) that limit the user's ability to safely participate in one or more MRADL's / ADL's?			
If yes, can they be accomodated / compensated for to allow use of a mobility assistive device to participate in MRADL's?			
Explain:			
3. Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device?			
Explain:			
4. Can the mobility deficit be sufficiently resolved with only the use of a cane or walker?			
Explain:			
5. Does the user's environment support the use of a: MANUAL WHEELCHAIR POV POWER WHEELCHAIR			
Explain:			
6. If a manual wheelchair is recommended, does the user have sufficient function / abilities to use the recommended equipment?			
Explain:			
7. If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it?			
Explain:			
8. If a power wheelchair is recommended, does the user have sufficient function / abilities to use the recommended equipment?			
Explain:			

PART K: RECOMMENDATIONS / GOALS

MANUAL WHEELCHAIR
POV
POWER WHEELCHAIR
POSITIONING SYSTEM (TILT/RECLINE/ELEV/STANDING)
SEATING

Continued

MAT EVALUATION: SITTING OR SUPINE

HEAD & NECK

POSTURE:

Functional | Flexed
Extended | Rotated
Laterally Flexed | Cervical Hyperextension

FUNCTION:

Good Head Control | Adequate Head Control
Limited Head Control | Absent Head Control

Support Needed: _____

Comments: _____

_____

UPPER EXTREMITY

SHOULDERS:

	Left	Right
WFL	_____	_____
Elev/dep	_____	_____
Pro/retract	_____	_____
Subluxed	_____	_____

Range of Motion (R.O.M.): _____

Strength: _____

Support Needed: _____

Comments: _____

_____

ELBOWS:

	Left	Right
Impaired	_____	_____
WFL	_____	_____

Range of Motion (R.O.M.): _____

Strength: _____

Support Needed: _____

Comments: _____

_____

WRIST & HAND

	Left	Right
Impaired	_____	_____
WFL	_____	_____

Strength/Dexterity: _____

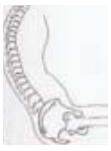
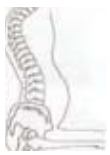
Support Needed: _____

Comments: _____

_____

TRUNK

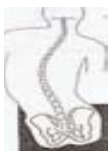
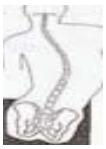
Anterior / Posterior

WFL | ↑ Thoracic Kyphosis | ↑ Lumbar Lordosis

Fixed | Flexible
Partly Flexible | Other

Left / Right

WFL | Convex Left | Convex Right

Fixed | Flexible
Partly Flexible | Other

Rotation

- Neutral
Left Forward
Right Forward

Fixed | Flexible
Partly Flexible | Other

Support Needed: _____

Continued

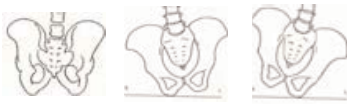
MAT EVALUATION: (Continued)

PELVIS

ANTERIOR / POSTERIOR

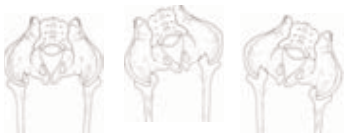
Neutral Posterior Anterior
Fixed Flexible
Partly Flexible Other

OBLIQUITY



WFL Left Lower Rt. Lower
Fixed Flexible
Partly Flexible Other

ROTATION



WFL Right Left
Fixed Flexible
Partly Flexible Other

Support Needed: _____

HIPS

POSITION

Neutral ABduct ADduct

Fixed Subluxed
Partly Flexible Dislocated
Flexible

WINDSWEPT

Neutral Right Left

Fixed Partly Flexible
Flexible Other

RANGE OF MOTION

	Left	Right
Flex:	_____°	_____°
Ext:	_____°	_____°
Int R:	_____°	_____°
Ext R:	_____°	_____°

KNEES & FEET

KNEE R.O.M.

LEFT	RIGHT
WFL	WFL
Flex _____°	Flex _____°
Ext _____°	Ext _____°

Strength: _____

Hamstring R.O.M. Limitations: (Measured at ___o Hip Flex)
Left _____ Right _____

FOOT POSITIONING

LEFT	RIGHT
WFL	WFL
Dorsi-Flexed	Dorsi-Flexed
Plantar Flexed	Plantar Flexed
Inversion	Inversion
Eversion	Eversion

Foot Positioning Needs: _____
_____

MOBILITY

BALANCE

Sitting Balance	Standing Balance
WFL	WFL
Min Support	Min Support
Mod Support	Mod Support
Unable	Unable

TRANSFERS

Independent
Min Assist
Max Assist
Sliding Board
Lift / Sling Required

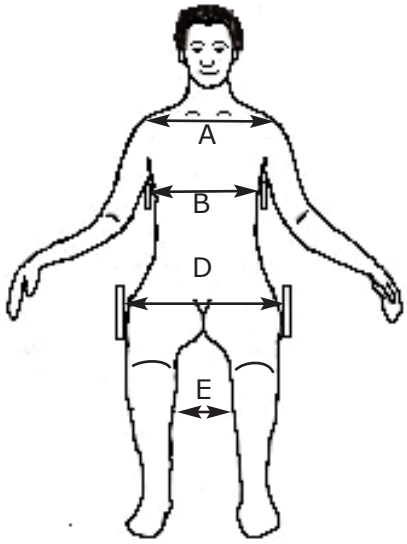
AMBULATION

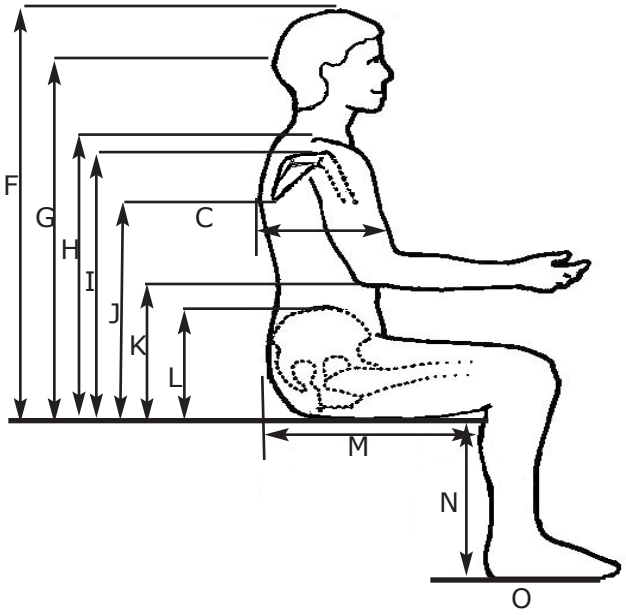
Unable to Ambulate
Ambulates with Assistance
Ambulates with Device
Independent without Device
Indep. Short Distance Only

Continued

MAT EVALUATION: (Continued)

MEASUREMENTS





		Measurements in Sitting:
	A	Shoulder Width
	B	Chest Width
	C	Chest Depth (Front – Back)
	D	Asymmetrical Hip Width**
	D	Hip Width
	E	Between Knees
	F	Top of Head
	G	Occiput

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

Right	Left		
			Degree of Hip Flexion
		H	Top of Shoulder
		I	Acromion Process (Tip of Shoulder)
		J	Inferior Angle of Scapula
		K	Elbow
		L	Iliac Crest
		M	Sacrum to Popliteal Fossa
		N	Knee to Heel
		O	Foot Length

Neuro-Muscular Status:

Tone: _____

Reflexive Responses: _____

Effect on Function: _____

Additional Comments: _____

_____

_____

Physical / Occupational Therapist: _____

Date: _____ Phone: (_____) _____

Physician Signature: (I have read and concur with the above assessment) _____

Date: _____ Phone: (_____) _____

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