

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: _____

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 \longleftrightarrow w/c Transfers					
w/c \longleftrightarrow 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: _____

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

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: _____

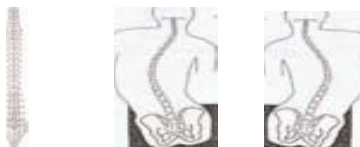
TRUNK

Anterior / Posterior



WFL	↑ Thoracic Kyphosis	↑ Lumbar Lordosis
Fixed	Flexible	Flexible
Partly Flexible	Other	Other

Left / Right



WFL	Convex Left	Convex Right
Fixed	Flexible	Flexible
Partly Flexible	Other	Other

Rotation



- Neutral
- Left Forward
- Right Forward

Fixed	Flexible
Partly Flexible	Other

Support Needed: _____

MAT EVALUATION: (Continued)

PELVIS

ANTERIOR / POSTERIOR



Neutral
Fixed
Partly Flexible

Posterior
Flexible
Other

Anterior

OBLIQUITY

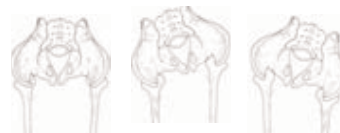


WFL
Fixed
Partly Flexible

Left Lower
Flexible
Other

Rt. Lower

ROTATION



WFL
Fixed
Partly Flexible

Right
Flexible
Other

Left

Support Needed: _____

HIPS

POSITION



Neutral
Fixed
Partly Flexible
Flexible

ABduct
Subluxed
Dislocated

ADduct

WINDSWEEP



Neutral
Fixed
Flexible

Right
Partly Flexible
Other

Left

RANGE OF MOTION



Left
Flex: ____°
Ext: ____°
Int R: ____°
Ext R: ____°

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 ____° 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

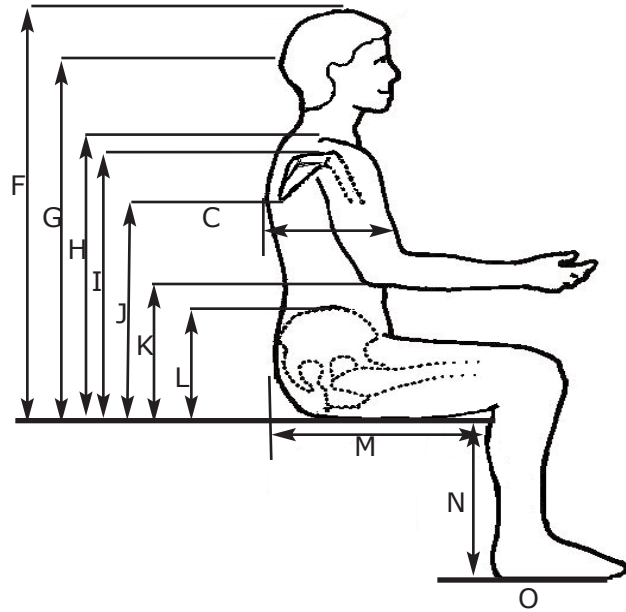
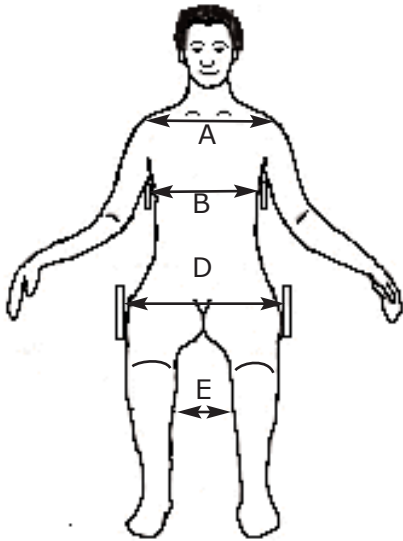
Ambulates with Device

Independent without Device

Indep. Short Distance Only

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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