Patient Name:

Manual Wheelchair Seating & Mobility Evaluation/Justification

To be completed by therapist

PATIENT INFORMATION: **Eval Date & Time:**

Patient Name: Sue Riceman	**DOB:** 1/15/1945 **Sex:** Female
Address: 555 Tropical Blvd, Florida	**Primary Insurance:** Medicare
Phone: **Email:**	**Policy #** _____
Physician: **Evaluating Therapist:** **Phone:** **Phone:**	**Secondary Insurance:** BCBS
Equipment Supplier Company Name: Medical Equipment Specialists **Contact at Company:** Mike Russo, ATP **Phone /Email:** 772-777-8109/ mikerusso@hmepartner.com	**Policy #** _____ **Other Insurance/Funding:**
Spouse/Parent/Caregiver Name: Paula Blue **Relationship:** Cousin **Phone/Email:**	
Client/Caregiver Goals: Tolerate prolonged sitting in wc for increased time, increased comfort, increased mobility	
Duration of Expected Need/Use for Mobility Equipment: lifetime	

MEDICAL HISTORY:

Primary Diagnosis/ICD-10 Codes: CVA, COPD, CHF, cervical spinal vascular anomaly	**Onset:** 2/2018
Secondary Diagnosis/Comorbidities/ICD-10 Codes: L side weakness, h/o stage 2 PU to sacrum	
Relevant Past and Future Surgeries: vascular surgery to correct anomaly occuluded blood flow to the spinal cord at base of brain	
Height: **Weight:** 5'7" 164 lbs	Explain recent changes or trends in weight within the past 5 years: weight fluctuations with CHF exaserbations

HOME ENVIRONMENT:

☒House	☐Apartment/Condo	☐Mobile Home	☐Assisted Living	☐LTCF	☐SNF	☐Other:
Home is Accessible to Equipment: ☒Yes	☐No	Stairs: ☐Yes	☒No	Ramp: ☒Yes	☐No	
☐Lives Alone / No Caregivers	☐Lives Alone / Caregiver Assist	☒Lives with Caregiver		Hours per Day Home Alone: 0		

SENSATION and SKIN INTEGRITY:

Sensation
☒Intact ☐Impaired ☐Absent
☐Hyposensate ☐Hypersensate
☐Defensiveness ☐Unable to report
Level or location of sensation:

Pressure Relief:
Able to perform effective pressure relief: ☐Yes ☒No
Describe observed successful method:
If no, why? Pt. with B UE/LE weakness, unable to perform a functional weight shift
☐Uses tilt or recline

Skin Integrity
Current Skin Issues: ☒Yes ☐No
☐Intact ☐Red area ☒Open area
Location(s): sacrum stage 2
Stage(s): _____
☐Scar tissue
☒At risk from prolonged sitting

History of Skin Issues: ☒Yes ☐No
Location: sacrum
When: _____
Stage(s): stage 2
Hx of skin flap surgeries: ☐Yes ☒No
Location: _____
When: _____

Risk factors
☐Braden Scale *(attached)* ☒ Immobility
☐Bony prominences ☒ Incontinence
☒Aging skin
☒Compromised circulatory status
☒Impaired nutritional or hydration status
☒Tendency towards moisture build-up *(profound perspiration, skin folds)*
☐Other:

CURRENT SEATING / MOBILITY:

Client currently has a wheelchair: ☒Yes ☐No	MFR Name: Invacare	Model: Tracer	
Age: Serial#:	Back support: std sling back	Seat cushion:	Basic Foam Cushion

Describe posture in present seating system:

Patient presents with posterior pelvic tilt, kyphotic spine, forward head and rounded shoulders posture. The LE in sitting are adducted and internally rotated due to poor support of the std seat sling, this LE positioning is forcing the lower legs to laterally adducted to be placed on the available foorplates.

Patient Name:

CURRENT SEATING / MOBILITY *(continued)*:

Current mobility equipment does not meet medical needs due to (limitations/issues):

On the edge of the therapy mat, the patient exhibits the ability to extend trunk and right the head to neutral with minimal cues but is min support on the edge of the mat for unsupported sitting balance. On the solid mat, the LE exhibit a more neutral position. The current seat sling and static seat angle of the DME chair does not support the patient's posture for maximizing ADLs. She is not in a position to adequately reach the push rims for optimal propulsion with the upper extremeties. She can use her R LE to assist with propulsion but the current seat to floor height is not optimal for foot propulsion.

ADL STATUS (in reference to wheelchair use):

	Indep	Super-vision	Assist (Min/Mod/Max)	Unable - Dependent	Not Assessed	From WC level	Comments:
Eating	x						
Meal Prep			max A				
Bathing			mod A				
Grooming			min A				
Toileting			min/mod A				indwelling catheter for bladder
Move Room to Room		X					
Community Mobility			mod				from wheelchair

AMBULATION:

☐Independent & Safe	☒Unable to functionally ambulate	**Comments:**
☐Ambulates with assistance	☒Non-Ambulatory	ambulation is therapeutic Only with mod A, RW
☐Ambulates with device	☒History of Falls	
☐Independent short distances only		

TRANSFERS

☐Independent ☒Min Assist ☐Mod Assist ☐Max Assist ☐Sliding board ☐Dependent ☐Lift / sling required

Comments: transfers range from min-mod A dependent on how pt. if feeling that day

ROM/STRENGTH:

ROM (WFL, WNL, Limitations)				Strength* (___ / 5)			
	Right	Left	Comments:		Right	Left	Comments/Concerns: *Including endurance, inconsistencies & time of day*
UE	3+	3		**UE**	3+	3	
LE	3+	3		**LE**	3+	3	L UE slightly apraxic c AROM

MEASUREMENTS:

	Left Side	Right Side
Buttock/Thigh Depth	19.5"	same as the L side
Lower Leg Length	17"	
Seat to Elbow	7"	
Top of Shoulder to Seat	20"	
Shoulder Width	17"	
Hip Width	18"	

BALANCE:

Sitting Balance ☐with ***OR*** ☒without UE Support	Standing Balance	Comments:
☐Normal / WFL	☐Normal / WFL	
☐Good / Min Assist	☐Good / Min Assist	
☒Fair / Mod Assist	☐Fair / Mod Assist	
☐Poor / Max Assist	☒Poor / Max Assist	
☐Unable / Dependent	☐Unable / Dependent	

Patient Name:

MOBILITY EQUIPMENT SKILLS:

Use of:	Safe, Indep., Functional Mobility	Risk or History of Falls	Environ-mental Limitations *(Describe)*	Safety & Cognitive Concerns	Decreased Endurance & Strength	Decreased Motor Skills, Balance, or Coordination	Pain	Pace/ Speed *(Describe)*	Cardiac / Respiratory Limitations	Comments:
Cane/ Crutches										
Walker		X		X	X	X			limited	
MWC Propulsion Arm: ☐left ☒right ☐both Foot: ☐left ☒right ☐both					Pt with decreased cardio-respiratory endurance					☐risk of repetitive strain injury ☐UE joint instability

Additional Comments: current MWC with Seat Height too tall for effective LE propulsion, pt. must compromise upright sitting postures to adequately reach the floor with LE

MANUAL WHEELCHAIR (MWC) \RECOMMENDATIONS and JUSTIFICATION

Recommended Mobility Base

MFR Name, Model, & Size: Ki Mobility, Liberty Folding Tilt, 18x18, 15" seat to floor height

General Justification: ☒provides mobility to usual and customary locations to participate in ADLs ☐promotes independent mobility

☒not a safe & functional ambulator ☒full-time wheelchair user ☐part-time wheelchair user; hours spent in WC during the day:_____

☒non-ambulatory ☐non-standard width/depth necessary to accommodate anatomical measurement

☒limitation prevents from completing an ADL within a reasonable time frame ☒willing & motivated to use the wheelchair ordered

☐walker, cane or crutches are inadequate to meet in the home mobility needs due to: Pt. with a h/o multiple falls and h/o L hip fracture due to a fall, pt. unalbe to safely ambuluate in the home

☐Other: Requires a frame/base that allows for rear wheel adjustment to increase UE access to the rear wheel and for energy conservation during propulsion

A lower level mobility base would not be appropriate due to:

A lower level frame is not appropriate due to 1. unable to reach desired seat to floor height for LE propulsion 2. unable to move rear wheel for access and energy conservation stategy needed 3. due to general weaknesses throughout, the variable seat angle offered by the Liberty FT helps with gravity assisted positioning for improved posture which increases lung volume and provides proximal stability for distal function of wc propulsion with both the UE and LE. A standard DME K1-K4 chair does not meet the needs of the patient.

Lightweight Manual Wheelchair (K0003)

Justification:

☐medical condition and weight of wheelchair affect ability to functionally self-propel standard manual wheelchair

☐independently self-propels this recommended MWC base

☐willing and motivated to use

☐lower seat to floor height required to foot propel

☐short stature

☐unable to functionally propel a standard MWC due to:_____

☒Other: NA

High-Strength Lightweight Manual Wheelchair (K0004)

Justification:

☐medical condition and weight of wheelchair affect ability to self-propel while engaging in frequent MRADLs that cannot be performed in a standard or lightweight manual wheelchair

☐willing and motivated to use ☐independently & functionally self-propels the recommended MWC ☐short stature

☐lower seat to floor height of _____" is required to foot propel; this is not available on lower level MWCs

☐requires a minimally adjustable axle plate due to: _____

☐needs the following specific seat and/or back measurement(s): _____, which is unavailable on lower level MWCs

☒Other: NA

Patient Name:

Manual Tilt-in-Space (E1161)

Justification: ☒transfers ☐management of tone/spasticity ☒to stabilize pelvic position during foot or hemi-propulsion
☒to increase UE access to the rear wheels for effective hemi or 4-extremity propulsion ☐control edema ☒self-propels
☒change position against gravitational force on head & shoulders ☒to promote gravity assistance with independent or aided repositioning
☒requires changes in seat angles to relieve pain while sitting ☒caregiver is willing and able to provide assistance with the wheelchair
☒facilitate postural control/stability by: The change in seat angle A pt. with gravity assisted positioning of trunk/ shoulders/Head
☒requires changes in seat angle to: Requires one seat angle for comfort, proximal stability to promote distal functioning, promote pelvic positioning, but needs separate seat angle to facilitate STS transfer
☒requires varying seat angles – one for postural stability and a difference seat angle to facilitate transfers and/or to accomplish MRADLs
☒change position for weight shift; unable to perform functional weight shifts (to include both push-ups & leans)
☒to assist client with maintaining skin integrity due to inability to perform an effective pressure relief
☒at high risk for development of pressure wound due to: prolonged sitting and uable to adequate shift weight, has current pressure area on sacrum, incontinent
☐to achieve and maintain optimal head position for (i.e. safe swallow/eating, secretion management, improved respiratory function)
☒to improve functional reach for MRADLs (i.e. oral facial hygiene, grooming, toileting, meal preparation, meals, & computer access) by:
The varible seat angle allows for increased proximal stability for distal functioning=more stable to perform tasks from the wheelchair
☐requires assistance for positioning due to: _____
☐Other:

ACCESSORY AND SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Seat Cushion (Non-Custom)

MFR Name, Model, & Size: Ki Mobility Axiom Visco Foam Cushion

Justification *(supported in earlier pages of evaluation)*: ☐impaired sensation ☒pressure wounds present ☒neutralize LE
☒hx of pressure wounds ☒ increase pressure distribution ☐stabilize pelvis ☐stabilize/promote alignment
☐prevent pelvic extension ☐accommodate obliquity/rotation ☐accommodate multiple deformities ☒promote hip/ femur alignment
☐Other:

Back Cushion (Non-Custom)

MFR Name, Model, & Size: Ki MObility Axiom Posterior Back

Justification *(supported in earlier pages of evaluation)*: ☒provide support of significant postural asymmetries
☒provide posterior trunk support ☒provide posterior/lateral trunk support ☒provide lumbar/sacral support
☐accommodate deformity ☐accommodate or decrease tone ☐pressure relief over spinous processes ☒support trunk in midline
☐correct deformity 2° to: _____
☐Other:

Pelvic Positioner (E0978/K0108)

Style: ☒Belt ☐SubASIS bar ☐Dual Pull ☐Padded ☐4-Point Belt ☐Other:

Justification: ☐stabilize tone ☐prevent excessive rotation ☒safety ☐pad for protection over boney prominence
☒decreased endurance/fatigue issues ☐special pull angle to control rotation ☐upper body instability ☒weak upper body muscles
☐decrease falling out of chair *(will not decrease potential for sliding due to pelvic tilting)* ☐Other:

Armrests (E0973, E2209, K0020)

Style: ☐fixed ☒adjustable height ☐removable ☐swing-away ☐flip-back ☐reclining ☒full length pads
☐desk-length pads ☐tubular ☐elbow support/elbow stop ☐arm trough: R___ L___ ☐Other:

Justification: ☐change height/angle for ADLs ☒support proper positioning/posture ☐allow to come closer to table top
☒accommodate seat-to-elbow measurement; fixed height armrest is not adequate ☒decreased muscle strength, coordination and control
☐provide support with elbow at 90°, not feasible with fixed height armrest due to anatomical measurements ☐remove for transfers
☐accommodate UE length of _____" ☐provide support for W/C tray ☐keep arms from falling off arm pad during tilt/recline
☐allow access to different parts of their environment throughout the day ☐position flaccid UE ☑use to perform pressure relief
☐abnormal tone ☐Other:

Patient Name:

Manual Footrests/ Legrests (E0990, K0053, K0195)

Style: ☐60° ☒70° ☐80° ☐90° ☐heavy-duty ☐fixed ☐lift-off ☐swing-away ☐elevating (ELRs) ☐articulating elevating ☐Other:

Justification: ☒provide LE support ☒enable transfers ☐accommodate knee ROM ☐manage tone/spasticity ☐elevate legs w/tilt and/or recline ☐durability ☐use in conjunction with tilt to decrease edema ☐provide change in position for legs ☐maintain feet on footplate ☐accommodate involuntary movement ☐ accommodate LE leg length ☐accommodate hamstring tightness by: _____ _____ ☐provide change in position for LEs for/due to: _____ _____ ☐Other:

☐Foot Support ☐Foot Box (E0954) ☐Shoe Holder/Ankle Positioner: ☐Right ☐Left

Style: ☐flip up ☐adjustable angle (K0040) ☐fixed/rigid foot platform ☐NA ☐Other:

Justification: ☐provide foot support ☐accommodate deformity ☐spasticity ☐poor motor control ☐stability ☐allow foot to be positioned under WC base ☐control position ☐decreased tone ☐increased tone ☐enable transfers ☐decreased strength in LEs ☐accommodate ankle ROM deficits/limitations ☐prevent foot/feet from falling off foot support ☐provide foot support with proper pressure distribution ☐abnormal reflexes affecting LEs ☐Other:

Headrest (E0955 or E0966) – Style: _____

Justification: ☐provide posterior head support ☐support while in tilt and/or recline ☐provide posterior neck support ☐provide lateral head support ☐provide anterior head support ☐accommodate tone ☐improve visual orientation ☐Other:

ADDITIONAL OPTIONS/ACCESSORIES with JUSTIFICATION

Option/Accessory: Wheellocks needed to increase access for patient safety during transfers
Option/Accessory: Antitippers needed for patient safety when navigating ramps and other uneven terrain.
Option/Accessory:
Option/Accessory:

By signing below, I attest that I personally performed this in-person evaluation and completed this evaluation form; I have no financial relationship with the mobility device provider supplying this equipment (listed on page 1):

Therapist Name Printed:		
Therapist's Signature		**Date:**

My signature below certifies that I agree with the recommendation above and order the equipment shown on the provider's itemized price list. This equipment is required for long term use.

Physician's Name Printed:		
Physician's Signature:		**Date:**