Patient Name:

Manual Wheelchair Seating & Mobility Evaluation/Justification

To be completed by therapist

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

Patient Name:		**DOB:** **Sex:**
Address:		**Primary Insurance:** **Policy #** _____ **Secondary Insurance:** **Policy #** _____ **Other Insurance/Funding:**
Phone:	**Email:**	
Physician: **Phone:**	**Evaluating Therapist:** **Phone:**	
Equipment Supplier Company Name: **Contact at Company:** **Phone /Email:**		
Spouse/Parent/Caregiver Name: **Relationship:** **Phone/Email:**		
Client/Caregiver Goals:		
Duration of Expected Need/Use for Mobility Equipment:		

MEDICAL HISTORY:

Primary Diagnosis/ICD-10 Codes: **Onset:**	
Secondary Diagnosis/Comorbidities/ICD-10 Codes:	
Relevant Past and Future Surgeries:	
Height: **Weight:**	Explain recent changes or trends in weight within the past 5 years:

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:		

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? ☐Uses tilt or recline	
Skin Integrity Current Skin Issues: ☐Yes ☐No ☐Intact ☐Red area ☐Open area Location(s): _____ Stage(s): _____ ☐Scar tissue ☐At risk from prolonged sitting	**History of Skin Issues:** ☐Yes ☐No Location: _____ When: _____ Stage(s): _____ 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:	Model:
Age: Serial#:	Back support:	Seat cushion:
Describe posture in present seating system:		

Patient Name:

CURRENT SEATING / MOBILITY *(continued)*:

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

ADL STATUS (in reference to wheelchair use):

	Indep	Super-vision	Assist (Min/Mod/Max)	Unable - Dependent	Not Assessed	From WC level	Comments:
Eating							
Meal Prep							
Bathing							
Grooming							
Toileting							
Move Room to Room							
Community Mobility							

AMBULATION:

☐Independent & Safe	☐Unable to functionally ambulate	**Comments:**
☐Ambulates with assistance	☐Non-Ambulatory	
☐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:

ROM/STRENGTH:

ROM (WFL, WNL, Limitations)				Strength* (___ / 5)			
	Right	**Left**	**Comments:**		**Right**	**Left**	**Comments/Concerns:** *Including endurance, inconsistencies & time of day*
UE				**UE**			
LE				**LE**			

MEASUREMENTS:

	Left Side	Right Side
Buttock/Thigh Depth		
Lower Leg Length		
Seat to Elbow		
Top of Shoulder to Seat		
Shoulder Width		
Hip Width		

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										
MWC Propulsion Arm: ☐left ☐right ☐both Foot: ☐left ☐right ☐both										☐risk of repetitive strain injury ☐UE joint instability
Additional Comments:										

MANUAL WHEELCHAIR (MWC) \RECOMMENDATIONS and JUSTIFICATION

Recommended Mobility Base

MFR Name, Model, & Size:

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: _____
_____
☐Other:

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

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:

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:

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: _____
_____
☐requires changes in seat angle to: _____
_____
☐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: _____
_____
☐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:
_____
_____
☐requires assistance for positioning due to: _____
☐Other:

ACCESSORY AND SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Seat Cushion (Non-Custom)

MFR Name, Model, & Size:

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:

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:
Option/Accessory:
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:**