Seating/Mobility Evaluation

Name:			Date Refe	rred:	Date of Eva	ıl:
Address:			Phone:		Physicia	n:
			Age:	Sex: _		Г:
Funding:			Height:		P	т:
Referred By:			Weight:		Soc. Sec. N	0:
Reason for Referral:						
Patient Goals:						
Caregiver Goals:						
MEDICAL HISTO	DRY:					
Dx:					ICD-10:	ICD-10: ICD-10:
Hx / Progression:						
Recent / Planned Surge	eries:					
Cardio-Respiratory Stat	us: Comme	nts:				
☐Intact: ☐Impaired:						
CURRENT SEAT	ING / MOE	BILITY: (Type	 Manufacture 	er – Model)		
Chair:				T		Age:
w/c Cushion:			Age:	w/c Back:		Age:
Reason for Replacer	ment / Repa	air / DUpdate:				
Funding Source:						
HOME ENVIRON	IMFNT:					
☐House ☐Apt	1	ng TITCE F	Alone w/ Family	v-Caregivers		
Entrance: Level	□Rai		□ Stair		Entrance Wid	lth:
w/c Accessible Rooms:			oorway Required to A		; 2.111.01.100 11.10	
Comments:	· · · · · · · · · · · · · · · · · · ·	•	·			
COMMUNITY AD	DL:					
TRANSPORTATION		/an □Bus □	Adapted w/c Lift	T Romp	☐ Ambulance ☐ Oth	nor:
Driving Poquiroments		van 🔟 DUS 🔟	Auapted W/C LITT L	⊸raπp	Ambulance LiOtr	ICI.
Driving Requirements: Employment / Education	alal Baguirama					
Other	nai Requireme	rits.				
COGNITIVE / VIS	SUAL STA	TUS				
Memory Skills	Intact:	Impaired:	Comments:			
Problem Solving	☐Intact:	☐Impaired:	Comments:			
Judgment	Intact:	☐Impaired:	Comments:			
Attn / Concentration	☐Intact:	☐Impaired:	Comments:			
Vision:	☐Intact:	☐Impaired:	Comments:			
Hearing:	☐Intact:	☐Impaired:	Comments:			
Other:	☐Intact:	☐Impaired:	Comments:			

Seating/Mobility Evaluation Continued

ADL STATUS:	Indep	Assist	Unable	Commer	nts / Other	AT Eq	uipment Requ	uired		
Dressing										
Bathing:										
Feeding:										
Grooming/Hygiene:										
Toileting										
Meal Prep										
Home Management										
Bowel Management:	Contir	nent 🔟	ncontinent							
Bladder Management:	Contin	······	ncontinent							
MOBILITY SKIL	LS:		Indep	Assist	Unable	N/A	Comments			
Bed ↔ w/c Transfer	's									
w/c ↔ Commode T	ransfers									
Ambulation:							Device:			
Manual w/c Propulsion	n:									
Operate Power w/c w		/stick								
Operate Power w/c \			ols 🗖							
Able to Perform Weig	ht Shifts						Туре:			
Hours Spent Sitting in		h Day:	•		Comments	:				
SENSATION:										
☐Intact ☐Impai	red	Absent	Hx of Pı	essure So	ores \square Y	es \square	No	Current Pressu	re Sores Yes	□No
Comments:								•		
			•••••••••••••••••••••••••••••••••••••••	••••	••••••					
CLINICAL CRIT	EDIA /	AL COD	ITUM CU		,					
Is there a mobility lim						ne or m	ore Mobility F	Related Activities	of Daily Living in	a reasonable time
frame? Explain:	nation oa	doing an ii	lability to oc	nory partic	лраю птог	10 01 11	ioro iviobility i	tolated / tolivilles	or bany Living in	Yes No
Are there cognitive or	sensory	deficits (a	wareness / j	udgemen	t / vision /	etc) tha	at limit the use	ers ability to safely	y participate in o	ne or more
MRADL'sADL's?										☐Yes ☐No
If yes, can they be ac Explain:	commoda	ated / com	pensated fo	r to allow	use of a m	nobility	assistive dev	ice to participate i	in MRADL's?	☐Yes ☐No
Does the user demor Explain:	strate the	e ability or	potential ab	ility and w	villingness	to safe	ely use the mo	bility assistive de	vice?	☐Yes ☐No
Can the mobility defice Explain:	cit be suffi	iciecntly re	solved with	only the u	use of a ca	ine or v	valker?			☐Yes ☐No
Does the user's envir Explain:	onment s	upprt the u	use of a	MANUAL	WHEELCH	AIR [DPOV D	Power W heelch	AIR:	☐Yes ☐No
If a manual wheelcha	ir is recor	mmended,	does the us	ser have s	ufficient fu	unction	/abilities to us	e the recommend	ded equipment?	☐Yes ☐No ☐N/A
If a POV is recomme Explain:	nded, doe	es the user	r have suffic	ient stabil	ity and up	perextr	emity function	n to operate it?		☐Yes ☐No ☐N/A
If a power wheelchai	r is recom	nmended,	does the us	er have si	ufficient fu	nction/	abilities to use	e the recommend	ed equipment?	□Yes □No □N/A
Explain:	TION /									I
RECOMMENDA MANUAL WHEEL			Powe	R Wheel	-HVID. L	TP 09	ITIONING S	VSTEM/TILT/DEGL	INE/ELEV/STANDI	ING) SEATING
WIANUAL WHEEL	-UNAIR L							N ATTACHE		ing, DOLATING
Physical / Occupation	nal Therap	oist:					Date		Phone:	
Physician: I have rea		ır					Date):	Phone:	

The information contained in this document was prepared solely to assist providers in preparing accurate, legitimate claims for reimbursement under Medicare, Medicaid and other insurance plans. Every attempt has been made to insure the information is accurate at the time of writing but payment policies, coverage guidelines and fee schedules change frequently. Nothing in these materials is intended to, or should be construed as a guarantee a claim will be paid and if paid, the amount. Questions on payment policy and coverage guidelines are best directed to the payor's ombusdperson or professional services department. Copyright 2005. All rights reserved.

Mat Evaluation: (Note if Assessed Sitting or Supine)

		POSTURE:		FU	INCTION	! :	COM	MENTS:	SUPPORT NEEDED
HE	AD	☐ Functional		☐ Good He	ad Control				
8	&	☐ Flexed ☐ Extended	4	☐ Adequate		ntrol			
NE	СК	☐ Rotated ☐ Latterally		☐ Limited Head Control					
Cervical Hyperextension		Absent H							
		Cervical Hyperextension	'	L Absent i	icau Conti	Oi			
		SHOULDERS		R.O.M.					
I	E	Left Rig	ıht						
	Χ	□wfl □wfl							
U .	Т	□elev / dep □elev		Strength:					
	R	□ pro / retract □ pro /	-	J					
	E	☐subluxed ☐sublu							
	M	ELBOWS	uxcu	R.O.M.					
_	i.		ight	11.0.11.					
	T		_	Strength:					
	Υ	☐ Impaired ☐ Impa	aired	Juengui.					
	•	□wfl □ wfl							
1675	10-			0((D 1 :	4			
	RIST	Left Righ		Strength /	Dexteri	ty:			
	&	☐ Impaired ☐ Impa							
НА	ND	OWFL OWFL					_		
	т	Anterior / Posteri	ior	I.	eft Right	12	Ro	tation	
	r R						of A	Neutral	
	U							Left Forward	
,	U	So Proposition		V			Forward	Right	
ı	N						1 Olwala		
ı	K		Lumbar	WFL	Convex	Convex			
		Kyphosis L	_ordosis		Left	Right			
		☐ Fixed ☐ Flex	vihle	☐ Fixed	П	Flexible	☐ Fixed	☐ Flexible	
		☐ Partly Flexible ☐ Other	1		exible \Box		Partly Fle		
		Anterior / Posteri			bliquity			otation	
ı	Р	A B	<u>ل</u> ـــا		Fi -	← H	AFDA o	13 N	
ı	E	19 20	8				(422)		
	L		7	(D)(G)	100	.00/.			
	٧								
	I S	Neutral Posterior An	nterior	WFL	Left Lower	Rt. Lower	WFL	Right Left	
•	3	☐ Fixed ☐ Othe	or	Fixed		Other	☐ Fixed	☐ Other	
		Partly Flexible	iei	Partly Fle		Other	Partly Fle		
		Flexible		☐ Flexible	SXIDIC		Flexible	SXIDIC	
		Position			indswep	4	Range	A	
		Tosition	FIT	**	iiiuswep	L	of	25	
	н	TAF TAF	7 - 1 -	(CS)	2	REST	Motion		
	I	71 71 71 7	M						
I	P								
;	S	Neutral ABduct AE	Dduct	Neutral	Right	Left	Left	。 Right	
							Flex:	0 0 0 0	
							Ext:		
		☐ Fixed ☐ Sub	oluxed	☐ Fixed		Other	Int R:	0 0	
		☐ Partly Flexible ☐ Disl	located	☐ Partly Fle	exible		Ext R:	00	
		☐ Flexible		☐ Flexible					

4 Evaluation

IVIAL L	evaluatio	TI. Conta				
	Knee	R.O.M.	Strength:	Foot Position	ning	Foot Positioning Needs:
	<u>Left</u>	Right		☐ WFL ☐	JL 🗆 R	
KNEES	☐ WFL	☐ WFL		☐ Dorsi-Flexed ☐	JL 🗆 R	
&	☐ Flex°	☐ Flex°	Hamstring ROM Limitations:	☐ Plantar Flexed ☐	JL 🗆 R	
FEET	☐ Ext°	☐ Ext°	(Measured at° Hip Flex)	☐ Inversion ☐	JL 🗖R	
			Left Right	☐ Eversion ☐	JL 🗆 R	
	Balance		Transfers	Ambulation	n	
	Sitting Balance:	Standing Balance	☐ Independent	☐ Unable to Ambulate	te	
MOBILITY	☐ WFL	☐ WFL	☐ Min Assist	☐ Ambulates with Ass	ssistance	
	☐ Min Support	Min Support	☐ Max Asst	☐ Ambulates with De	evice	
	☐ Mod Support	Mod Support	☐ Sliding Board	☐ Independent without	out Device	
	Unable	Unable	☐ Lift / Sling Required	☐ Indep. Short Distan	nce Only	
F G F			A B B D C C C C C C C C C C C C C C C C C	Re	Neuro- one: reflexive Res	

	Measurements in Sitting:	Left	Right		
A:	Shoulder Width				Degree of Hip Flexion
B:	Chest Width			H:	Top of Shoulder
C:	Chest Depth (Front – Back)			l:	Acromium Process (Tip of Shoulder)
D:	Hip Width			J:	Inferior Angle of Scapula
**	Asymmetrical Width			K:	Elbow
D:	Hip Width			L:	Iliac Crest
E:	Between Knees			M:	Sacrum to Popliteal Fossa
F:	Top of Head			N:	Knee to Heel
G:	Occiput			O:	Foot Length
Additional Co	mments:				
** Asymmetri	cal Width: i.e., windswept or scoliotic posture; measur	re widest p	oint to wide:	st poin	nt
	cupational Therapist:		Da		Phone:
Physician: I have read & concur with the above assessment				ate:	Phone:

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