Seating/Mobility Evaluation

Name:		Date Referred:		Date of Eval:	
Address:		Phone:		Physician:	
		Age:	Sex:	OT:	
Funding:		Height:		PT:	
Referred By:		Weight:		Soc. Sec. No:	

Reason for Referral:

Patient Goals:

Caregiver Goals:

MEDICAL HISTORY:

Dx: ICD-10: ICD-10:
ICD-10: ICD-10:

Hx / Progression:

Recent / Planned Surgeries:

Cardio-Respiratory Status:	Comments:
❒Intact: ❒Impaired:	

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

Chair: Age:

w/c Cushion: Age:	**w/c Back**: Age:

Reason for ❒Replacement / ❒Repair / ❒Update:

Funding Source:

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:

COMMUNITY ADL:

TRANSPORTATION: ❒Car ❒Van ❒Bus ❒Adapted w/c Lift ❒Ramp ❒ Ambulance ❒Other:

Driving Requirements:

Employment / Education\al Requirements:

Other

COGNITIVE / VISUAL STATUS:

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:

Continued

Seating/Mobility Evaluation Continued

ADL STATUS:	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		

MOBILITY SKILLS:	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:		

SENSATION:

❒Intact ❒Impaired ❒Absent	Hx of Pressure Sores ❒Yes ❒No	Current Pressure Sores ❒Yes ❒No
Comments:		

CLINICAL CRITERIA / ALGORITHM SUMMARY

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: ❒Yes ❒No

Are there cognitive or sensory deficits (awareness / judgement / vision / etc) that limit the users ability to safely participate in one or more MRADL'sADL's? ❒Yes ❒No

If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL's? ❒Yes ❒No

Explain:

Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? ❒Yes ❒No

Explain:

Can the mobility deficit be sufficiecntly resolved with only the use of a cane or walker? ❒Yes ❒No

Explain:

Does the user's environment supprt the use of a ❒ MANUAL WHEELCHAIR ❒ POV ❒POWER WHEELCHAIR: ❒Yes ❒No

Explain:

If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? ❒Yes ❒No ❒N/A

Explain:

If a POV is recommended, does the user have sufficient stability and upperextremity function to operate it? ❒Yes ❒No ❒N/A

Explain:

If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? ❒Yes ❒No ❒N/A

Explain:

RECOMMENDATION / GOALS:

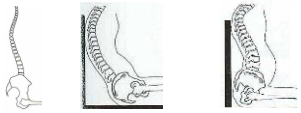
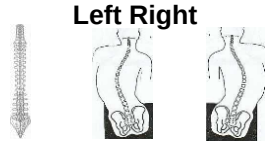
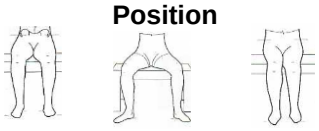
❒ **MANUAL** WHEELCHAIR ❒ **POV** ❒**POWER** WHEELCHAIR: ❒**POSITIONING SYSTEM**(TILT/RECLINE/ELEV/STANDING) ❒**SEATING**

SEE SEPARATE JUSTIFICATION ATTACHED

Physical / Occupational Therapist: _____ Date: _____ Phone: _____

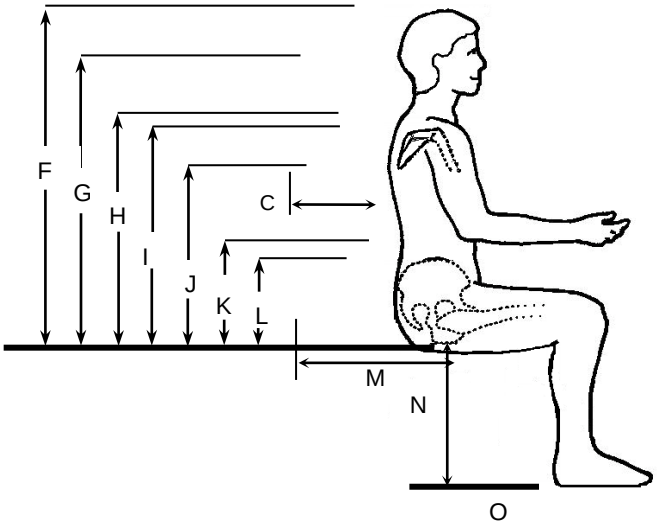
Physician: I have read & concur with the above assessment _____ Date: _____ Phone: _____

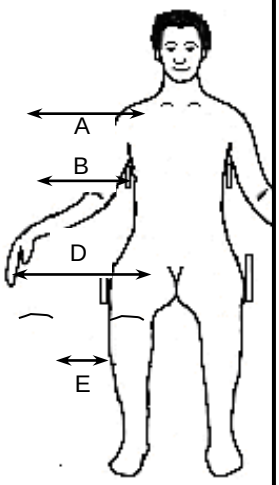
Mat Evaluation: (NOTE IF ASSESSED SITTING OR SUPINE)

	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	❒ Functional ❒ Flexed ❒ Extended ❒ Rotated ❒ Latterally Flexed ❒ Cervical Hyperextension	❒ Good Head Control ❒ Adequate Head Control ❒ Limited Head Control ❒ Absent Head Control		
UPPER EXTREMITY	**SHOULDERS** **Left** **Right** ❒WFL ❒WFL ❒elev / dep ❒elev / dep ❒pro / retract ❒pro / retract ❒subluxed ❒subluxed	**R.O.M.** **Strength:**		
	ELBOWS **Left** **Right** ❒Impaired ❒ Impaired ❒WFL ❒ WFL	**R.O.M.** **Strength:**		
WRIST & HAND	**Left** **Right** ❒Impaired ❒Impaired ❒WFL ❒WFL	**Strength / Dexterity:**		
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	
PELVIS	**Anterior / Posterior**  ❒ Neutral ❒ Posterior ❒ Anterior ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Obliquity**  ❒ WFL ❒ Left Lower ❒ Rt. Lower ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Rotation**  ❒ WFL ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	
HIPS	**Position**  ❒ Neutral ❒ ABduct ❒ ADduct ❒ Fixed ❒ Subluxed ❒ Partly Flexible ❒ Dislocated ❒ Flexible	**Windswept**  ❒ Neutral ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Range of Motion**  **Left** **Right** Flex: _____ o _____ o Ext: _____ o _____ o Int R: _____ o _____ o Ext R: _____ o _____ o	

Mat Evaluation: Cont'd

KNEES & FEET	**Knee R.O.M.** Left / Right ❒ WFL ❒ WFL ❒ Flex_____° ❒ Flex_____° ❒ Ext _____° ❒ Ext _____°	Strength: Hamstring ROM Limitations: (Measured at ___° Hip Flex) Left_____ Right_____	**Foot Positioning** ❒ WFL ❒L ❒R ❒ Dorsi-Flexed ❒L ❒R ❒ Plantar Flexed ❒L ❒R ❒ Inversion ❒L ❒R ❒ Eversion ❒L ❒R	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 Asst ❒ Sliding Board ❒ Lift / Sling Required	**Ambulation** ❒ Unable to Ambulate ❒ Ambulates with Assistance ❒ Ambulates with Device ❒ Independent without Device ❒ Indep. Short Distance Only	





Neuro-Muscular Status:

Tone:

Reflexive Responses:

Effect on Function:

	Measurements in Sitting:	Left	Right		
	A: Shoulder Width				Degree of Hip Flexion
	B: Chest Width			**H:**	Top of Shoulder
	C: Chest Depth (Front – Back)			**I:**	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 Comments:

_____

_____

_____

_____

_____

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

Physical / Occupational Therapist: _____ Date: _____ Phone: _____

Physician: I have read & concur with the above assessment _____ Date: _____ Phone: _____