Custom Wheelchair Evaluation

The intent of this form is to secure sufficient information to determine the medical necessity for a custom wheelchair.

This form must be completed by the licensed therapist or the certified physiatrist performing the evaluation.

Recipient Name:		Date Referred:	Date of Evaluation:
Address:		Phone:	Physician:
		Age: Sex:	OT:
Funding:		Date of Birth:	PT:
Referred By:		Height:	
		Weight:	
Medicaid ID #			

Reason for Referral:

Patient Goals:

Caregiver Goals:

MEDICAL HISTORY:

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

Date of injury/onset:

Prognosis/ Hx:

Recent / Planned Surgeries:

Cardio-Respiratory Status: ☐ Intact ☐ Impaired

Comments:

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

Chair: Age:

Serial #

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

Other Positioning Components:

Reason for ☐ Replacement / ☐ Repair / ☐ Update:

Funding Source:

HOME ENVIRONMENT:

☐ House ☐ Apt ☐ Asst Living ☐ LTCF ☐ Alone ☐ w/ Family-Caregivers:

Length of time at residence:

Entrance: ☐ Level ☐ Ramp ☐ Lift ☐ Stairs Entrance Width:

w/c Accessible Rooms: ☐ Yes ☐ No Narrowest Doorway Required to Access:

Is a caregiver available 24 hours a day: ☐ Yes ☐ No If no, how many hours a day is a caregiver available?

Comments:

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

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	☐	☐	☐	☐	
Ability to Stand	☐	☐	☐	☐	
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 Location/Stage

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 / judgment / vision / etc) that limit the users' ability to safely participate in one or more MRADL's or ADL'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 sufficiently resolved with only the use of a cane or walker? ☐ Yes ☐ No

Explain:

Does the user's environment support 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 upper extremity function to operate it? ☐Yes ☐No ☐N/A

Explain:

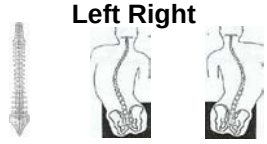
If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? ☐Yes ☐No ☐N/A

Explain:

RECOMMENDATION / GOALS:

☐ **MANUAL** WHEELCHAIR ☐ **POV** ☐**POWER WHEELCHAIR:** ☐**POSITIONING SYSTEM**(TILT/RECLINE) ☐**SEATING**

Mat Evaluation: (NOTE IF ASSESSED SITTING OR SUPINE)

	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	☐ Functional ☐ Flexed ☐ Extended ☐ Rotated ☐ Laterally Flexed ☐ Cervical Hyperextension	☐ Good Head Control ☐ Adequate Head Control ☐ Limited Head Control ☐ Absent Head Control ☐ Tone/ Reflex		
UPPER EXTREMITY	**SHOULDERS** **Left** / **Right** ☐WFL ☐WFL ☐elev / dep ☐elev / dep ☐pro / retract ☐pro / retract ☐subluxed ☐subluxed	**R.O.M.** **Strength:** **Tone/Reflex:**		
	ELBOWS **Left** / **Right** ☐Impaired ☐Impaired ☐WFL ☐WFL	**R.O.M.** **Strength:** **Tone/Reflex:**		
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

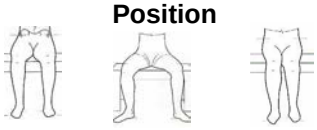
Rotation

☐ 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

KNEES & FEET

Knee R.O.M.

Left	Right
☐ WFL	☐ WFL
☐ Flex_____ o	☐ Flex_____ o
☐ Ext _____ o	☐ Ext _____ o

Strength:

Hamstring ROM Limitations:
(Measured at ___ o Hip Flex)
Left_____ Right_____
Orthosis?
Prosthetic?

Foot Positioning

☐ WFL	☐ L	☐ R
☐ Dorsi-Flexed	☐ L	☐ R
☐ Plantar Flexed	☐ L	☐ R
☐ Inversion	☐ L	☐ R
☐ Eversion	☐ L	☐ R

Foot Positioning Needs:

MOBILITY

Balance

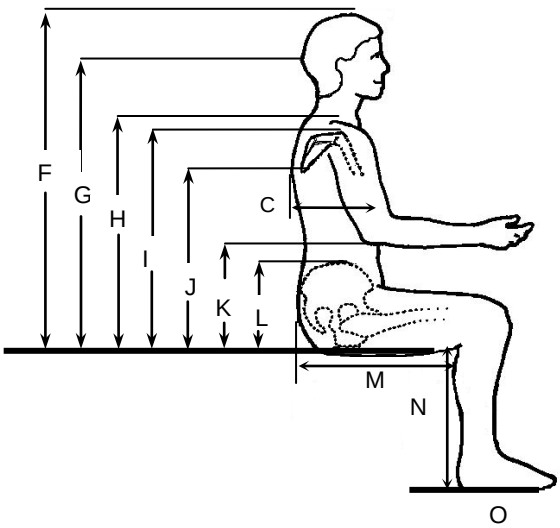
Sitting Balance:	Standing Balance
☐ WFL	☐ WFL
☐ Min Support	☐ Min Support
☐ Mod Support	☐ Mod Support
☐ Unable	☐ Unable

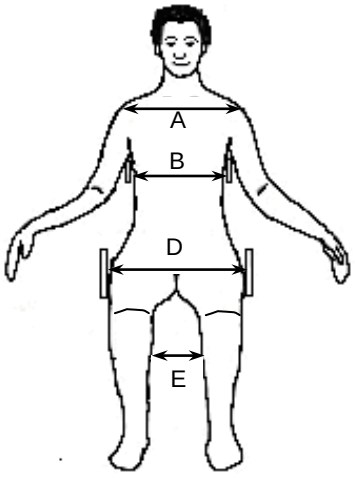
Transfers

☐ 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				
	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
	E: Between Knees			**L:**	Iliac Crest
	F: Top of Head			**M:**	Sacrum to Popliteal Fossa
	G: Occiput			**N:**	Knee to Heel
				O:	Foot Length

Additional Comments and please add Trunk and Pelvic width with brace/ Orthosis, when applicable.
****** Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point

REQUESTED EQUIPMENT:

Requested Frame (make and model):
Dimensions:
Amount of growth available:

SIGNATURE:

As the evaluating therapist, I hereby attest that I have personally completed this five page evaluation form and that I am not an employee of or working under contract to the manufacturer(s) or the provider(s) of the durable medical equipment recommended in my evaluation. I further attest that I have not and will not receive remunerations of any kind from the manufacturer(s) or the Durable Medical Equipment provider(s) for the equipment I have recommended with this evaluation.

	License #
☐ Physical Therapy license	
☐ Occupational Therapy license	
☐ Physiatrist board certification	

_____ _____ _____

Signature, as it appears on license or certification ***Date*** ***Daytime contact number(s)***

_____ _____ _____

Fax Number ***Email Address*** ***Cell phone number (optional)***

Optional:

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