MOBILITY EVALUATION – POWER WHEELCHAIR

Date: _____ **Referred By:** _____

SECTION I. PATIENT INFORMATION

Name: _____ **Birth Date:** _____ **Medicare/Insurance #:** _____

Address: _____ **City:** _____ **State:** _____

Phone Number: _____ **DOB** _____ **Sex:** _____ **Height:** _____ **Weight:** _____

What type of environment does the patient reside in (Example: 1 story home, an apartment complex; please give full detail): _____

SECTION II. MEDICAL HISTORY

Date or onset of condition/injury requiring use of wheelchair : _____

Diagnosis (es) (*Please include written description and ICD–9 Codes*): _____

_____

How has the patient's condition progressed to now requiring power mobility: _____

_____

Patient's Current Ambulatory Status (*Please include any assistive device, physical assistance, and degree of assistance required*): _____

_____

_____

Patient's Current Ability to Perform Activities of Daily Living in Home (*Please include any assistive device, physical assistance, and degree of assistance required*): _____

_____

_____

IS THE PATIENT:

Bed confined: _____ **hours per day**_____ **Chair confined:** _____ **hours per day** _____

Present Equipment - Make: _____ **Model:** _____ **Age of Equipment:** _____

Number of Hours / Day in Wheelchair _____ **Est. Length of Need (# of Months, 99=lifetime)**_____

Reason for Replacement: _____

IS THE PATIENT CAPABLE OF USING:

Standard or light weight wheelchair within the home (*please detail*): _____

_____

POV/Scooter within the home (*please detail*): _____

_____

Completion of this Evaluation does not guarantee Coverage or Insurance Reimbursement

PATIENT NAME: _____ **DATE:** _____

Functional Status (*Please provide quantitative measurements*):

ROM Limitations: _____

Muscle Strength Limitations: _____

Upper Extremity Function: _____

Lower Extremity Function: _____

Ability to Transfer: _____

Endurance: _____

SECTION III. SPECIAL SEATING REQUIREMENTS - complete for any type of special seating (*Please explain current limitations and any specialty seating required due to these limitations*)

Sitting Posture/Balance: _____

Pelvic Tilt/ Obliquity/Rotation: _____

Leg Position: _____

Scoliosis: _____

Lordosis /Kyphosis: _____

Head Position: _____

Shoulder/Scapula Position: _____

Movement/Strength: _____

Tone/Spasms: _____

Skeletal/Physical Limitations/Deformities/Abnormalities: _____

_____

SPECIAL SEAT MEASUREMENTS: Seat Width: _____ **Seat Depth:** _____ **Knee to Heel:** _____

Shoulder to Elbow: _____ **Top of Shoulder:** _____ **Inferior of Scapula:** _____

SKIN CONDITION/INTEGRITY

Susceptible to decubitus ulcers: ☐ **NO** ☐ **YES** **if yes, explain:**

Sensation: _____

Present/history of Ulcers: _____

Location(s): _____

Stage: _____

Ability to perform pressure relief: _____

Bowel/Bladder status (toileting): _____

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PATIENT NAME: _____ **DATE:** _____

SECTION IV. ADDITIONAL QUESTIONS FOR MEDICAL NECESSITY

Please assess the general systems of this patient:

Vision:

Hearing:

Communication:

Cognitive Level:

Respiratory:

Eating:

Has the patient been evaluated using the power wheelchair in the home? _____

Can the patient safely operate the controls of the power wheelchair? _____

Where will the patient use the equipment? _____

What is the benefit of a power wheelchair for this patient? _____

_____

Recommendations

Mobility Base - Specify make/model: _____

Option – Specify each option/accessory and why the item is required for this patient:

_____

_____

Seating – Specify any special seating components, including supports and why the item is required for this patient:

_____

_____

Vendor Information:

Equipment Supplier _____

Date _____

I have reviewed Section I, II, III, and IV of this clinical assessment and agree that it is an accurate assessment of the client and their needs.

THERAPIST'S NAME: _____ **PHYSICIAN'S NAME:** _____

ADDRESS: _____ **ADDRESS:** _____

SIGNATURE: _____ **DATE:** _____ **SIGNATURE:** _____ **DATE:** _____

LICENSE # _____ **UPIN:** _____

Completion of this Evaluation does not guarantee Coverage or Insurance Reimbursement