Wheelchair Seating and Positioning Evaluation

Name:
Date:
MR #:
Account #:
Birth Date: Sex:
Physician:

PATIENT INFORMATION:

Name:	**Physician:**	**Date seen:** **Time:**
Address:	**Physician Fax #:** **Seating Therapist:** **Phone:**	***This evaluation/justification form will serve as the LMN for the following suppliers*:** **Supplier/Vendor:** **CRS** • NuMotion **Acute Medicaid/DD** • Preferred Homecare **Rehabilitation Technology Supplier:**
Phone:	**Primary Therapist:**	
Spouse/Parent/Caregiver name: **Phone number:**	**Insurance/Payer:** **Recipient #**	
Reason for Referral	Per MD orders " wheelchair seating and positioning evaluation".	
Patient Goals:		
Caregiver goals and specific limitations that may effect care:		

MEDICAL HISTORY:

Diagnosis:	ICD10 Code:	**Primary Diagnosis:**	ICD10 Code:	Diagnosis:
	ICD10 Code:	Diagnosis:	ICD10 Code:	Diagnosis:
❒Progressive Disease	**Relevant past and future surgeries:**			
Height:	**Weight:**	Explain recent changes or trends in weight:		
History:				
Cardio Status:	Functional Limitations:			
❒Intact ❒ Impaired ❒Severely Impaired ❒ NA				
Respiratory Status:	Functional Limitations:			
❒Intact ❒Impaired ❒Severely Impaired ❒ NA				
Orthotics:				

HOME ENVIRONMENT:

❒House❒ Condo/town home ❒Apartment ❒Asst Living ❒LTCF	❒own ❒rent
❒Lives Alone ❒ Lives with Others	Hours with caregiver:
❒Home is accessible to patient ***Comments:***	**Storage of Wheelchair:** ❒In home ❒other **Stairs** ❒Yes ❒No

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COMMUNITY ADL:

TRANSPORTATION: ❒Hand Controls ❒L❒R ❒Other:
❒Car ❒Van ❒Public Transportation ❒Adapted w/c Lift ❒ SUV ❒Other: ❒Sits in wheelchair during transport

Where is w/c stored during transport? ❒Tie Downs ❒Easy Lock

❒Self Driver Drive while in Wheelchair ❒yes ❒no

Employment:
Specific requirements pertaining to mobility

School:
Specific requirements pertaining to mobility

Total Hours/day in this mobility system:

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: ❒Right ❒Left ❒NA Comments:

Functional Processing Skills for Wheeled Mobility
❒Processing Skills are adequate for safe wheelchair operation
Comments:

COMMUNICATION:

Verbal Communication ❒WFL receptive ❒ WFL expressive ❒Understandable ❒Difficult to understand ❒non-communicative
❒Uses an augmentative communication device Manufacturer/Model :

AAC Mount Needed:

SENSATION and SKIN ISSUES:

Sensation
❒Intact ❒Impaired ❒Absent
❒Hyposensate ❒Hypersensate
❒Defensiveness
Level of sensation:

Pressure Relief:
Able to perform effective pressure relief : ❒Yes ❒ No
Method: ❒press up ❒side to side ❒sit to stand ❒chest to knees
If not, Why?:

Skin Issues/Skin Integrity
Current Skin Issues ❒Yes ❒No
❒Intact ❒ Red area❒ Open Area
❒Scar Tissue ❒At risk from prolonged sitting
Where ______________________________

History of Skin Issues ❒Yes ❒No
Where ______________________________
____
When ______________________________

Hx of skin flap surgeries ❒Yes ❒No
Where ______________________________
____
When ______________________________

Complaint of Pain: 0 1 2 3 4 5 6 7 8 9 10
Where: Type: ❒burning ❒stabbing ❒banding ❒dull ❒______________________

ADL STATUS (in reference to wheelchair use):

	Indep	Assist	Unable	Indep with Equip	Not assessed	Comments
Dressing						
Eating						Describe oral motor skills
Grooming/Hygiene						
Meal Prep						
IADLS						
Bowel Mngmnt: ❒Continent ❒Incontinent ❒Accidents						Comments:
Bladder Mngmnt: ❒Continent ❒Incontinent ❒Accidents						Comments:

CURRENT SEATING / MOBILITY:

Current Mobility Base: ❒None ❒Dependent ❒Dependent with Tilt ❒Manual ❒Scooter ❒Power Type of Control:

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Manufacturer:	Model:	Serial #:
Size:	Color:	Age:

Current Condition of Mobility Base:

Current Seating System: Age of Seating System:

COMPONENT	MANUFACTURER	CONDITION
Seat Base	❐Solid ❐Sling ❐other:	
Cushion		
Back		
Lateral trunk supports		
Knee support		
Foot support/strap		
Head Support		
Pelvic Stabilization		
Anterior Chest/Shoulder Support		
UE Support		
Other:		
	STF front: STF back:	
When relevant:	Overall seat height Overall w/c length	Overall w/c width

Reason for replacement, repair or update:

WHEELCHAIR SKILLS: (current skills and shown by trial)

	Indep	Assist	Dependent/ unable	N/A	Comments
Bed ↔ w/c Chair Transfers	❐	❐	❐	❐	
w/c ↔ Commode Transfers	❐	❐	❐	❐	
Operate Scooter	❐ Strength, hand grip, balance , transfer appropriate for use. ❐ Living environment appropriate for scooter use.				
Operate Power w/c: Std. Joystick	❐	❐	❐	❐	❐Safe ❐ Functional Distance
Operate Power w/c: w/ Alternative Controls	❐	❐	❐	❐	❐Safe ❐ Functional Distance

MOBILITY/BALANCE:

Balance		Transfers	Ambulation
Sitting Balance:	Standing Balance	❐ Independent	❐ Independent
❐ WFL	❐ WFL	❐ Min Assist	❐ Ambulates with Asst
❐Uses UE for balance in sitting	❐Min assist	❐ Mod Asst	❐ Ambulates with Device
❐ Min Assist	❐ Mod assist	❐Max assist	❐ Indep. Short Distance Only
❐ Mod Assist	❐Max assist	❐ Dependent	❐ Unable to Ambulate
❐Max Assist	❐ Unable	❐ Sliding Board	
❐ Unable		❐ Lift / Sling Required	

Comments:

MAT EVALUATION:

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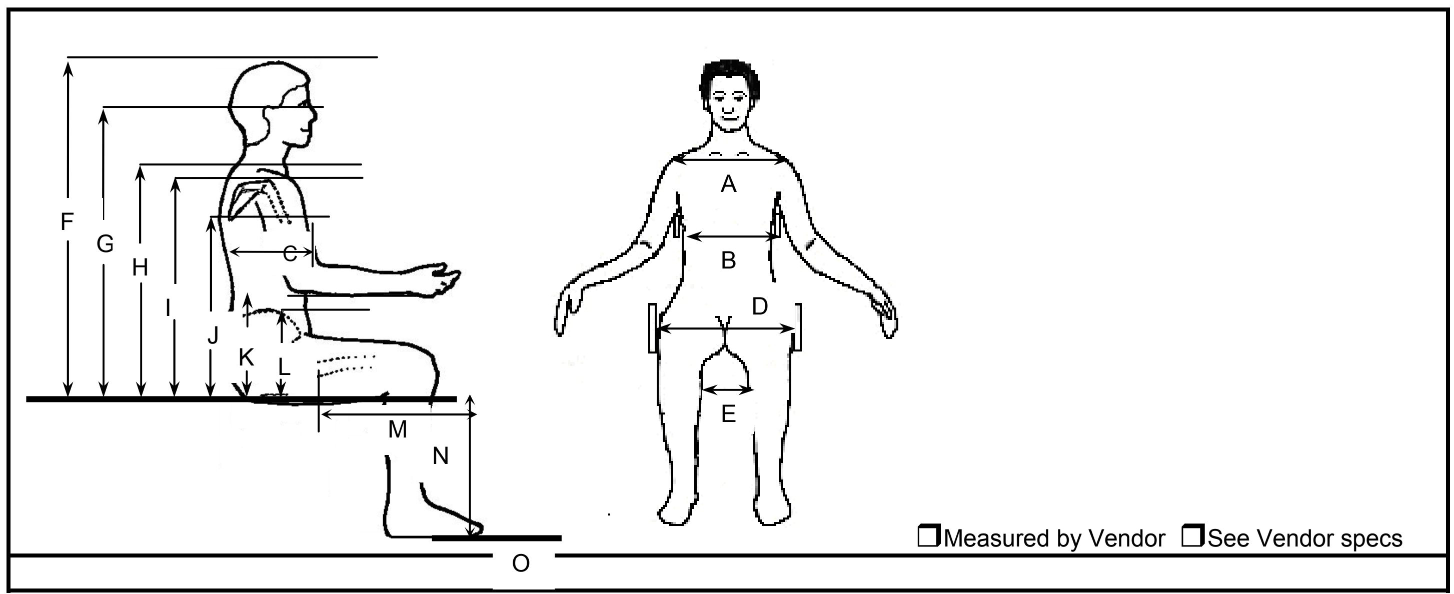

		Measurements in Sitting:	**Left**	**Right**		
	A:	Shoulder Width				
	B:	Chest Width			**H:**	Seat to Top of Shoulder
	C:	Chest Depth (Front – Back)			**I:**	Acromium Process (Tip of Shoulder)
	D.	Hip width			**J:**	Inferior Angle of Scapula
	E.	Between Knees			**K:**	Seat to Elbow
	F.	Top of Head			**L:**	Seat to Iliac Crest
	G.	Occiput			**M:**	Upper leg length
	++	Overall width (asymmetrical width for windswept legs or scoliotic posture			**N:**	Lower leg length
					O:	Foot Length

Additional Comments:

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

EXPLAIN WHY PATIENT IS NON-AMBULATORY:

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POSTURE:				COMMENTS:
PELVIS	**Anterior / Posterior** ❐ Neutral ❐ Posterior ❐ Anterior ❐ Fixed ❐ Other ❐ Partly Flexible ❐ Flexible	**Obliquity** ❐ WFL ❐ R elev ❐ l elev ❐ Fixed ❐ Other ❐ Partly Flexible ❐ Flexible	**Rotation-Pelvis** ❐ WFL ❐ Right Anterior ❐ Left Anterior ❐ Fixed ❐ Other ❐ Partly Flexible ❐ Flexible	
TRUNK	**Anterior / Posterior** ❐ WFL ❐ ↑ Thoracic Kyphosis ❐ ↑ Lumbar Lordosis ❐ Fixed ❐ Flexible ❐ Partly Flexible ❐ Other	**Left Right** ❐ WFL ❐ Convex Left ❐ Convex Right ❐c-curve ❐s-curve ❐multiple ❐ Fixed ❐ Flexible ❐ Partly Flexible ❐ Other	**Rotation-shoulders and upper trunk** ❐ Neutral ❐ Left-anterior ❐ Right-anterior ❐ Fixed ❐ Flexible ❐ Partly Flexible ❐ Other	
	Describe LE Neurological Influence/Tone: **Hamstring flexibility: Pelvis to thigh angle** ❐accommodate greater than 90 **Thigh to calf angle** ❐ accommodate less than 90			
HIPS	**Position** ❐ Neutral ❐ ABduct ❐ ADduct ❐ Fixed ❐ Subluxed ❐ Partly Flexible ❐ Dislocated ❐ Flexible	**Windswept** ❐ Neutral ❐ Right ❐ Left ❐ Fixed ❐ Other ❐ Partly Flexible ❐ Flexible	**Hip Flexion/Extension Limitations:** **Hip Internal/External Range of motion Limitations:**	
KNEES & FEET	**Knee R.O.M.** Left: ❐ WFL ❐Limitations Right: ❐ WFL ❐Limitations		**Foot Positioning** ❐ WFL ❐L ❐R ROM concerns: Dorsi-Flexed ❐L ❐R Plantar Flexed ❐L ❐R Inversion ❐L ❐R Eversion ❐L ❐R	

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POSTURE:				COMMENTS:
HEAD & NECK	❒ Functional ❒ Flexed ❒ Extended ❒ Rotated L ❒ Lat Flexed L ❒ Rotated R ❒ Lat Flexed R ❒ Cervical Hyperextension	❒ Good Head Control ❒ Adequate Head Control ❒ Limited Head Control ❒ Absent Head Control	**Describe Tone/Movement of head and Neck:**	
UPPER EXTREMITY	**SHOULDERS** **Left** **Right** ❒Functional ❒Functional ❒elev / dep ❒elev / dep ❒pro-retract ❒pro-retract ❒subluxed ❒subluxed	**R.O.M. for Upper Extremity** ❒WNL ❒WFL Limitations: **UE Strength Concerns:** ❒ **N/A** ❒ **None** ❒**Concerns:**	**Describe Tone/Movement of UE:**	
	ELBOWS **Left** **Right**	**R.O.M.** **Strength concerns:**		
WRIST & HAND	**Left** **Right** ❒Fisting ❒Tenodesis	**Strength / Dexterity:**		

Equipment trials:

State why other equipment was not appropriate/ successful:

Treatment Plan:

- ❒ The patient and/or caregiver actively participate in appointment for fitting and training with recommended equipment.
- ❒ The patient and/or caregiver will demonstrate adequate knowledge of safe and functional operation of the recommended equipment
- ❒ The patient and/or caregiver will demonstrate adequate knowledge on use and care of the recommended equipment
- ❒

Goals for Wheelchair Mobility for Client:

- ❒ Provide independence in mobility in the home and motor related ADLs (MRADLs) in the community
- ❒ Client to be independent with relieving pressure in the wheelchair
- ❒Provide wheelchair base that includes **tilt** to facilitate pressure relief and postural control
- ❒Provide wheelchair base that includes **recline** to facilitate pressure relief and postural control

Goals for Seating system for Client:

- ❒ Optimize pressure distribution to assist in the prevention of decubitus ulcers
- ❒ Provide support needed to facilitate function and safety
- ❒ Provide corrective forces to assist with maintaining or improving posture
- ❒ Accommodate and support client’s posture: current seated postures and positions are not flexible or will not tolerate corrective forces
- ❒Enhance physiological function such as breathing, swallowing, digestion

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THERE WILL BE NO SUBSTITUTIONS FOR THE SPECIFIC RECOMMENDATIONS AS STATED BELOW.

_____ New Mobility Base ______Modify Curent Seating System (keep same base)

MOBILITY BASE	JUSTIFICATION	
Manufacturer: **Model:** **Color:** Size: Width Seat Depth	❒provide transport from point A to B ❒promote Indep mobility ❒is not a safe, functional ambulator ❒walker or cane inadequate	❒non-standard width/depth necessary to accommodate anatomical measurement ❒
❒**Scooter/POV**	❒can safely operate ❒can safely transfer	❒has adequate trunk stability ❒can not functionally propel manual wheelchair
❒**Powered Mobility**	❒non-ambulatory ❒can not functionally propel manual wheelchair	❒ can not functionally and safely operate scooter/POV
Tilt Base or added ❒Forward ❒Backward ❒Powered tilt on powered chair	❒ change position against gravitational force on head and shoulders ❒change position for pressure relief/can not weight shift ❒transfers	❒management of tone ❒rest periods ❒control edema ❒facilitate postural control ❒
Recline ❒Power recline on power base	❒ accommodate femur to back angle ❒ bring to full recline for ADL care ❒ change position for pressure relief/can not weight shift	❒rest periods ❒repositioning for transfers or clothing/diaper /catheter changes ❒head positioning
❒**Transportation tie-down option**	❒to provide crash tested tie down brackets	
Elevator on Mobility Base ❒Wheelchair ❒Scooter	❒increase Indep in transfers ❒increase Indep in ADLs	❒raise height for communication at standing level ❒
Heavy Duty required	❒user weight greater than 250 pounds ❒extreme tone	❒broken frame on previous chair ❒multiple seat functions ❒over active movement
Specific seat height required Floor to seat height	❒transfers ❒accommodation of leg length	❒access to table or desk top ❒

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MOBILITY BASE	JUSTIFICATION	
POWER WHEELCHAIR CONTROLS ❒**Proportional** Type Body Parts Left Right ❒**Non-Proportional/switches** Type Body Parts **Upgraded Electronics** ❒ ❒**Display box** ❒Digital interface electronics ❒ASL Head Array ❒**Sip and puff tubing kit** ❒Upgraded tracking electronics ❒**Safety Reset Switches** ❒Single or Multiple Actuator Control Module	❒provides access for controlling wheelchair ❒ lacks motor control to operate proportional drive control ❒ unable to understand proportional controls ❒programming for accurate control ❒progressive Disease/changing condition ❒Needed in order to operate power/tilt through joystick control ❒Allows user to see in which mode and drive the wheelchair is set; necessary for alternate controls ❒Allows w/c to operate when using alternative drive controls ❒Allows client to operate wheelchair through switches placed in tri-panel headrest ❒needed to operate sip and puff drive controls ❒increase safety when driving ❒ correct tracking when on uneven surfaces ❒Used to change modes and stop the wheelchair when driving in latch mode ❒ Allow the client to operate the power seat function(s) through the joystick contorl	❒non-proportional drive control needed ❒Needed to operate tilt through single switch
❒**Mount for switches or joystick**	❒Attaches switches to w/c ❒Swing away for access or transfers	❒midline for optimal placement ❒provides for consistent access
Attendant controlled joystick plus mount	❒safety ❒long distance driving ❒operation of seat functions	❒compliance with transportation regulations
Battery	❒power motor on wheelchair	
Charger	❒charge battery for wheelchair	

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MOBILITY BASE	JUSTIFICATION	
Hangers/ Leg rests 60 70 80 90 elevating heavy duty articulating fixed lift off power elevating swing away rotational hanger brackets adjustable knee angle adjustable calf panel Longer extension tube	provide LE support accommodate to hamstring tightness elevate legs during recline provide change in position for LEs Maintain placement of feet on footplate	durability enable transfers decrease edema Accommodate lower leg length
Foot plate adjustable Footplate R L flip up depth/angle adjustable	provide foot support accommodate to ankle ROM allow foot to go under wheelchair base	transfers
Armrests fixed adjustable height removable swing away dual post adjustable flip back reclining full length pads desk pads tubular	provide support with elbow at 90 provide support for w/c tray change of height/angles for variable activities	remove for transfers allow to come closer to table top remove for access to tables
Side guards/hip guides	prevent clothing getting caught in wheel or becoming soiled	Allow hips/thighs to remain in midline position
Tires: pneumatic flat free inserts solid	prevent frequent flats increase shock absorbency decrease maintenance	decrease pain from road shock decrease spasms from road shock
Shock absorbers	decrease vibration	provide smoother ride over rough terrain
Other:		

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SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Type	Justification	
Seat Cushion		❐accommodate impaired sensation ❐decubitus ulcers present ❐prevent pelvic extension ❐low maintenance	❐stabilize pelvis ❐accommodate obliquity ❐accommodate multiple deformity ❐neutralize LE ❐increase pressure distribution ❐
Cover Replacement		❐protect back or seat cushion	❐
Mounting hardware ❐lateral trunk supports ❐headrest ❐medial thigh support ❐back ❐seat	❐fixed ❐swing away for:	❐attach seat platform/cushion to w/c frame ❐attach back cushion to w/c frame	❐mount headrest ❐swing medial thigh support away ❐swing lateral supports away for transfers ☐
Back		❐provide lateral trunk support ❐accommodate deformity ❐accommodate or decrease tone ❐facilitate tone	❐provide posterior trunk support ❐provide lumbar/sacral support ❐support trunk in midline ❐
Lateral pelvic/thigh support		❐ pelvis in neutral ❐accommodate pelvis ❐position upper legs	❐accommodate tone ❐removable for transfers ❐
Medial/ lateral Knee Support		❐decrease adduction ❐accommodate ROM	❐remove for transfers ❐alignment
Foot Support		❐position foot ❐accommodate deformity	❐stability/control position ❐decrease tone
Ankle strap/heel loops		❐support foot on foot support ❐decrease extraneous movement	❐provide input to heel ❐protect foot
Lateral trunk Supports	❐R ❐L	❐decrease lateral trunk leaning ❐accommodate asymmetry ❐contour for increased contact	❐safety ❐control of tone ❐
Anterior chest strap, vest, or shoulder retractors		❐decrease forward movement of shoulder ❐accommodation of TLSO ❐decrease forward movement of trunk	❐added abdominal support ❐alignment ❐assistance with shoulder control ❐decrease shoulder elevation

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SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manuf/ mod/size	Justification	
Headrest		❐provide posterior head support ❐provide posterior neck support ❐provide lateral head support ❐provide anterior head support ❐support during tilt and recline ❐improve feeding	❐improve respiration ❐placement of switches ❐safety ❐accommodate ROM ❐accommodate tone ❐improve visual orientation
Neck Support		❐decrease neck rotation	❐decrease forward neck flexion
Upper Extremity Support ❐Arm trough ❐Posterior hand support ❐½ tray ❐full tray ❐swivel mount	❐R ❐L	❐decrease edema ❐decrease subluxation ❐control tone ❐provide work surface ❐placement for AAC/Computer/EADL	❐decrease gravitational pull on shoulders ❐provide midline positioning ❐provide support to increase UE function ❐provide hand support in natural position
Pelvic Positioner ❐Belt ❐SubASIS bar ❐Dual Pull		❐stabilize tone ❐decrease falling out of chair/ **will not decrease potential for sliding due to pelvic tilting ❐prevent excessive rotation	❐pad for protection over boney prominence ❐prominence comfort ❐special pull angle to control rotation ❐
Bag or pouch		**Holds:** ❐medicines ❐special food ❐orthotics ❐clothing changes	❐diapers ❐catheter/hygiene ❐ostomy supplies ❐
Other			

Therapist Name Printed:		
Therapist's Signature		**Date:**
Supplier's Name Printed:		
Supplier's Signature:		**Date:**

I agree with the above findings and recommendations of the therapist and supplier AND THERE WILL BE NO SUBSTITUTIONS FOR THE SPECIFIC RECOMMENDATIONS AS STATED HERE.

Physician's Name Printed:		
Physician's Signature:		**Date:**

This is to certify that I, the above signed therapist, have the following affiliations:

❐This DME provider
❐Manufacturer of recommended equipment
❐Patient's long term care facility
❐None of the above