**SEATING/MOBILITY EVALUATION**

**PATIENT INFORMATION:**

|  |  |  |
| --- | --- | --- |
| Name:      Address:         Insurance:       Referred By:      Fax:       | Date Referred:      Phone:      Age:       Sex:      Height:     Weight:     DOB:      Onset Date:       | Date Seen:      Time in:       Time out:      CPT Codes:      PT:       Facility:       |
|  |  |  |

Present at the evaluation were:

Patient Goals:

Caregiver Goals:

**MEDICAL HISTORY:**

Dx:

Treatment Dx:

ICD-9:

Hx/Progression:

Surgical History:

Cardio-Respiratory Status: [ ] WFL [ ] Impaired Comments:

**HOME ENVIRONMENT:**

[ ] House [ ] Apt. [ ] Asst’d Living [ ] Caregivers/Family [ ] Lives Alone

Entrance: [ ] Level [ ] Ramp [ ] Lift [ ] Stairs Entrance Width:

Narrowest Doorway to Access:

 Location:

Wheelchair Accessible Rooms: [ ] Yes [ ] No Comments:

**TRANSPORTATION:**

[ ] Car [ ] Van [ ] Van/Lift [ ] Bus [ ] Bus/Lift [ ] Ambulance [ ] Other

Transfer Requirements:

Driving Requirements:

Comments:

**ENVIRONMENT AND INTENDED USE**

Please indicate your expectations of use for a new mobility device, if requested:

|  |  |  |
| --- | --- | --- |
|  **Expected Use**  **Place** | **Full Time** | **Part Time** |
| Home |       |       |
| School |       |       |
| Work |       |       |
| Leisure/Recreation |       |       |

Comments:

**CURRENT SEATING / MOBILITY:**

Chair:

 Age:

Wheelchair cushion:

 Age:

Wheelchair back:

 Age:

Wheelchair (reason for replacement):

Seating (reason for replacement):

Length of need:

**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 | Sup | Min | Max | Dep | Comments |
| Bathing | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Dressing/Bathing | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Feeding | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Grooming/Hygiene | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Toileting | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Meal Prep | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Home Management (laundry) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |

Bowel Management: [ ] Continent [ ] Incontinent Comments:

Bladder Management: [ ] Continent [ ] Incontinent Comments:

**WHEELCHAIR SKILLS:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Indep | Sup | Assist | Unable | N/A | Comments |
| Bed↔Chair Transfers | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Chair↔Commode Transfers | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Manual w/c Propulsion | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Power w/c Operation: Std Joystick | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Power w/c Operation: Alt Controls | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |
| Able to perform weight shifts | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |       |

Bed Confined without w/c: [ ] Yes [ ] No

 Comments:

**SENSATION:**

Intact: [ ] Yes [ ] No

Impaired: [ ] Yes [ ] No

Absent: [ ] Yes [ ] No

Comments:

Pain:

 Rest [ ] Yes [ ] No Location:

 With mobility [ ] Yes [ ] No

 Prolonged sitting [ ] Yes [ ] No

 Comments:

History of Pressure Sores: [ ] Yes [ ] No

Current Pressure Sores: [ ] Yes [ ] No

Comments:

Ambulation Assistance:

Ambulation Device:

Ambulation Distance:

|  |  |
| --- | --- |
| 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 MR ADL’s? If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL’s?  Explain:       | [ ] Yes [ ] No |
| Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device?  Explain:       | [ ] Yes [ ] No |
| Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? Explain:       | [ ] Yes [ ] No |
| Does the user’s environment support the use of a [ ] Manual Wheelchair [ ] POV [ ] Power Wheelchair Explain:       | [ ] Yes [ ] No |
| If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? Explain:       | [ ] Yes [ ] No [ ] N/A |
| If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it? Explain:       | [ ] Yes [ ] No [ ] N/A |
| If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? Explain:       | [ ] Yes [ ] No [ ] N/A |

**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 |       |       |
|  E XU TP RP EE MR I T Y | SHOULDERS | R.O.M.:  |       |       |
|  | Left[ ] WFL[ ] elev [ ]  dep[ ] pro[ ] retract[ ] subluxed | Right[ ]  WFL[ ]  elev [ ]  dep[ ] pro[ ] retract[ ] subluxed | Strength:       |       |       |
|  | ELBOWS | R.O.M.: Strength:       |       |       |
|  | Left[ ] Impaired[ ] WFL | Right[ ] Impaired[ ] WFL |  |  |  |
| WRIST&HAND | Left[ ] Impaired[ ] WFL | Right[ ] Impaired[ ] WFL | Strength/Dexterity:       |       |       |
| TRUNK | Anterior/Posterior | Left Right [ ]  [ ]  [ ] WFL Convex ConvexLeft Right[ ] Fixed[ ] Partly Flexible[ ] Flexible [ ] Other  | Rotation[ ]  Neutral[ ] Left Forward[ ] Right Forward[ ] Fixed [ ] Flexible[ ] Partly Flexible [ ] Other |       |
|  |  |  |  |  |
|  | [ ] WFL | [ ] ↑ThoracicKyphosis | [ ] ↑LumbarLordosis |  |  |  |
|  | [ ] Fixed[ ] Partly Flexible | [ ] Flexible[ ] Other |  |  |  |
| PELVIS | Anterior/Posterior[ ]  [ ]  [ ] Neutral Posterior Anterior[ ] Fixed [ ] Partly Flexible[ ] Flexible [ ] Other  | Obliquity[ ]  [ ]  [ ] WFL Left Lower Rt Lower[ ] Fixed [ ] Partly Flexible[ ] Flexible [ ] Other | Rotation[ ]  [ ]  [ ] WFL Right Left[ ] Fixed [ ] Partly Flexible[ ] Flexible [ ] Other |       |
| HIPS | Position[ ]  [ ]  [ ] Neutral ABduct ADduct[ ] Fixed [ ] Partly Flexible[ ] Flexible [ ] Subluxed[ ] Dislocated  | Windswept[ ] Neutral [ ] Right [ ] Left[ ] Fixed [ ] Partly Flexible[ ] Flexible [ ] Other  | Left RightFlex:     º      ºExt:     º      ºInt R:     º      ºExt R:     º      º |       |
| KNEES&FEET | Knee R.O.M | Strength:      Hamstring ROM Limitations:     (Measured at      º Hip Flex)Left       Right      | Foot Positioning | Foot Positioning Needs:       |
|  | Left[ ] WFL[ ] Flex      º[ ] Ext      º | Right[ ] WFL[ ] Flex      º[ ] Ext      º |  | [ ] WFL[ ] Dorsi-flexed[ ] Plantar Flexed[ ] Inversion[ ] Eversion | [ ] L [ ] R[ ] L [ ] R[ ] L [ ] R[ ] L [ ] R[ ] L [ ] R |  |
| Mobility | Balance | Transfers[ ]  Independent[ ] Min Assist[ ] Max Assist[ ] Sliding Board[ ] Lift / Sling required | Ambulation[ ] Unable to ambulate[ ] Ambulates with Assistance[ ] Ambulates with Device[ ] Independent without Device[ ] Indep. Short Distance Only |       |
|  | Sitting | Standing  |  |  |  |
|  | [ ] WFL | [ ] WFL |  |  |  |
|  | [ ] Min Support | [ ] Min Support |  |  |  |
|  | [ ] Mod Support | [ ] Mod Support |  |  |  |
|  | [ ] Unable | [ ] Unable |  |  |  |
|  | Neuro-Muscular Status:Tone:      Reflexive Responses:      Effect on Function:       |
|  | Measurements in Sitting: | Left | Right | Degree of Hip Flexion |
|       | A: Shoulder Width |       |       | H: Top of Shoulder |
|       | B: Chest Width |       |       | I: Acromium Process (Tip of Shoulder) |
|       | C: Chest Depth (front-back) |       |       | J: Inferior Angle of Scapula |
|       | D: Hip Width |       |       | K: Elbow |
|       | \*\* Asymmetrical Width |       |       | L: Iliac Crest |
|       | D: Hip Width |       |       | M: Sacrum to Popliteal Fossa |
|       | E.: Between Knees |       |       | N: Knee to Heel |
|       | F: Top of Head |       |       | O: Foot Length |
|       | G: Occiput |       |       |  |
| Additional Comments:       |
| \*\*Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point |

**GOALS/OBJECTIVES OF SEATING / MOBILITY INTERVENTION:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Date Set | Problem | Type | Time Frame | Goal Description | Status | Date Met |
|       |       | [ ] STG[ ] LTG |    visit |       | [ ] Met[ ] Not Met[ ] Ongoing[ ] Partially Met |       |
|       |       | [ ] STG[ ] LTG |    visit |       | [ ] Met[ ] Not Met[ ] Ongoing[ ] Partially Met |       |
|       |       | [ ] STG[ ] LTG |    visit |       | [ ] Met[ ] Not Met[ ] Ongoing[ ] Partially Met |       |

**EQUIPMENT RECOMMENDATIONS:**

|  |  |
| --- | --- |
| OPTION/ACCESSORY | JUSTIFICATION |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |
|       |       |

**PLAN:** Delivery of Equipment To: [ ]  Emory CRM [ ]  Home [ ] Other

1.
2.
3.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Physical Therapist: |  | Date:       | Phone:       |
|       |  |  |  |
|  |  |  |  |
| ATP, CRTS: |  | Date:       | Phone:       |
|       |       |  |  |
|  |  |  |  |
|  |  |  |  |
| Physician: I have read & Concur with the above assessment: |  |  |  |
| Date:       | Phone:       |
|  |  |       |  |  |