

Seating/Mobility Evaluation

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

Reason for Referral: _____

Patient Goals: _____

Caregiver Goals: _____

MEDICAL HISTORY:

Dx: _____ ICD-9: _____ ICD-9: _____
 _____ ICD-9: _____ ICD-9: _____

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 / Educational Requirements: _____

Other: _____

COGNITIVE / VISUAL STATUS:

Memory Skills	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Problem Solving	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Judgment	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Attn / Concentration	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Vision:	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Hearing:	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:
Other:	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments:

Continued

Seating/Mobility Evaluation Continued

ADL STATUS:	Indep	Assist	Unable	Comments / Other AT Equipment Required
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming/Hygiene:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Home Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Management:	<input type="checkbox"/> Continent		<input type="checkbox"/> Incontinent	
Bladder Management:	<input type="checkbox"/> Continent		<input type="checkbox"/> Incontinent	

MOBILITY SKILLS:	Indep	Assist	Unable	N/A	Comments
Bed ↔ w/c Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
w/c ↔ Commode Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ambulation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Device:
Manual w/c Propulsion:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Perform Weight Shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type:
Hours Spent Sitting in w/c Each Day:	Comments:				

SENSATION:

<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Absent	Hx of Pressure Sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Current Pressure Sores	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there cognitive or sensory deficits (awareness / judgement / vision / etc) that limit the users ability to safely participate in one or more MRADL's/ADL's? If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL's? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the user's environment support the use of a <input type="checkbox"/> MANUAL WHEELCHAIR <input type="checkbox"/> POV <input type="checkbox"/> POWER WHEELCHAIR? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If a POV is recommended, does the user have sufficient stability and upperextremity function to operate it? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

RECOMMENDATION / GOALS:

<input type="checkbox"/> MANUAL WHEELCHAIR <input type="checkbox"/> POV <input type="checkbox"/> POWER WHEELCHAIR: <input type="checkbox"/> POSITIONING SYSTEM (TILT/RECLINE/ELEV/STANDING) <input type="checkbox"/> SEATING
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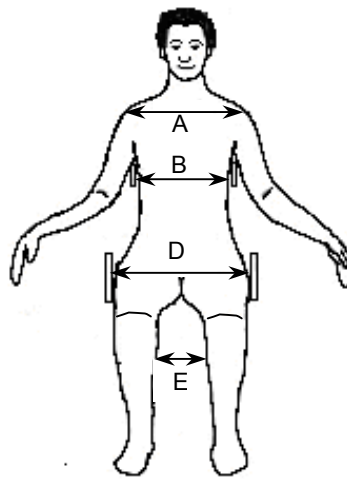
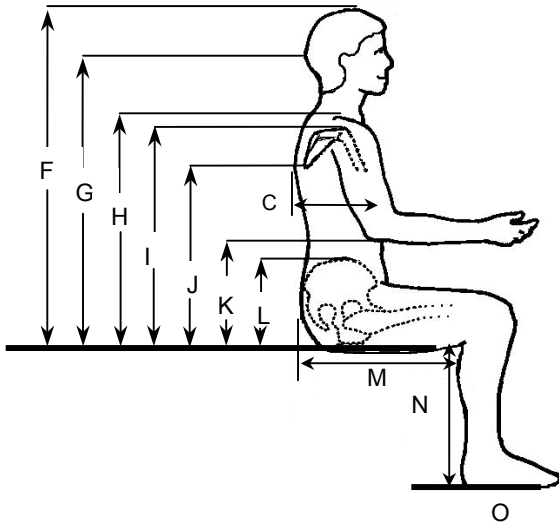
Physical / Occupational Therapist: _____	Date: _____	Phone: _____
Physician: I have read & concur with the above assessment _____	Date: _____	Phone: _____

Mat Evaluation: (NOTE IF ASSESSED SITTING OR SUPINE)

	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated <input type="checkbox"/> Laterally Flexed <input type="checkbox"/> Cervical Hyperextension	<input type="checkbox"/> Good Head Control <input type="checkbox"/> Adequate Head Control <input type="checkbox"/> Limited Head Control <input type="checkbox"/> Absent Head Control		
EXTREMITY	SHOULDERS Left Right <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> elev / dep <input type="checkbox"/> elev / dep <input type="checkbox"/> pro / retract <input type="checkbox"/> pro / retract <input type="checkbox"/> subluxed <input type="checkbox"/> subluxed	R.O.M. Strength:		
	ELBOWS Left Right <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	R.O.M. Strength:		
WRIST & HAND	Left Right <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	Strength / Dexterity:		
TRUNK	Anterior / Posterior  <input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic Kyphosis <input type="checkbox"/> ↑ Lumbar Lordosis <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	Left Right  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	Rotation  <input type="checkbox"/> Neutral <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	
PELVIS	Anterior / Posterior  <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	Obliquity  <input type="checkbox"/> WFL <input type="checkbox"/> Left Lower <input type="checkbox"/> Rt. Lower <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	Rotation  <input type="checkbox"/> WFL <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	
HIPS	Position  <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct <input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible	Windswept  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	Range of Motion  Left Right Flex: _____ ° _____ ° Ext: _____ ° _____ ° Int R: _____ ° _____ ° Ext R: _____ ° _____ °	

Mat Evaluation: Cont'd

KNEES & FEET	Knee R.O.M.		Strength: Hamstring ROM Limitations: (Measured at ___° Hip Flex) Left _____ Right _____	Foot Positioning		Foot Positioning Needs:
	<u>Left</u>	<u>Right</u>		<input type="checkbox"/> WFL	<input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> WFL	<input type="checkbox"/> WFL		<input type="checkbox"/> Dorsi-Flexed	<input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> Flex _____°	<input type="checkbox"/> Flex _____°		<input type="checkbox"/> Plantar Flexed	<input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> Ext _____°	<input type="checkbox"/> Ext _____°		<input type="checkbox"/> Inversion	<input type="checkbox"/> L <input type="checkbox"/> R	
				<input type="checkbox"/> Eversion	<input type="checkbox"/> L <input type="checkbox"/> R	
MOBILITY	Balance		Transfers	Ambulation		
	Sitting Balance:	Standing Balance:		<input type="checkbox"/> Independent	<input type="checkbox"/> Unable to Ambulate	
	<input type="checkbox"/> WFL	<input type="checkbox"/> WFL		<input type="checkbox"/> Min Assist	<input type="checkbox"/> Ambulates with Assistance	
	<input type="checkbox"/> Min Support	<input type="checkbox"/> Min Support		<input type="checkbox"/> Max Asst	<input type="checkbox"/> Ambulates with Device	
	<input type="checkbox"/> Mod Support	<input type="checkbox"/> Mod Support		<input type="checkbox"/> Sliding Board	<input type="checkbox"/> Independent without Device	
<input type="checkbox"/> Unable	<input type="checkbox"/> Unable	<input type="checkbox"/> Lift / Sling Required	<input type="checkbox"/> 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
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: _____