**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  X  U T  P R  P E  E M  R I  T  Y | SHOULDERS | | | | | | | R.O.M.: | | |  | | |  | |
|  | Left  WFL  elev  dep  proretract  subluxed | | | Right  WFL  elev  dep  proretract  subluxed | | | | Strength: | | |  | | |  | |
|  | ELBOWS | | | | | | | R.O.M.:  Strength: | | |  | | |  | |
|  | Left  Impaired  WFL | | | Right  Impaired  WFL | | | |  | | |  | | |  | |
| WRIST  &  HAND | Left  Impaired  WFL | | | Right  Impaired  WFL | | | | Strength/Dexterity: | | |  | | |  | |
| T  R  U  N  K | Anterior/Posterior | | | | | | | Left Right      WFL Convex Convex  Left Right  Fixed  Partly Flexible  Flexible Other | | | Rotation    Neutral  Left Forward  Right Forward  Fixed Flexible  Partly Flexible Other | | |  | |
|  |  | | | | | | |  | | |  | | |  | |
|  | WFL | | ↑Thoracic  Kyphosis | | | ↑Lumbar  Lordosis | |  | | |  | | |  | |
|  | Fixed  Partly Flexible | | | Flexible  Other | | | |  | | |  | | |  | |
| P  E  L  V  I  S | 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 | | |  | |
| H  I  P  S | Position      Neutral ABduct ADduct  Fixed Partly Flexible  Flexible Subluxed  Dislocated | | | | | | | Windswept    Neutral Right Left  Fixed Partly Flexible  Flexible Other | | | Left Right  Flex:     º      º  Ext:     º      º  Int R:     º      º  Ext 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



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