

# Seating/Mobility Evaluation

To be completed by Physiatrist or Physical/Occupational Therapist  
In Association With Mobility Device Specialist

## PATIENT INFORMATION:

<b>Name:</b>	<b>DOB:</b>	<b>Sex:</b>	<b>Evaluation Date:</b>
<b>Address:</b>	<b>Physician:</b>		<i><b>This form will serve as the LMN for the following suppliers:</b></i> <b>Primary :</b>  Contact Name : Phone #:
	<b>Mobility Device Therapist:</b>		
<b>Phone #:</b>	<b>License #:</b>	<b>Phone #:</b>	
<b>Spouse/Parent/Caregiver/Guardian Name:</b>	<b>Mobility Device Specialist: Title, &amp; Phone #:</b>		<b>Rehabilitation Engineering Program or 2<sup>nd</sup> Supplier:</b>  Contact Name: Phone #:
<b>Relationship:</b>	<b>Primary Therapist: Phone #:</b>		
<b>Phone #:</b>	<b>Insurance/Payer: Patient Recipient #:</b>		
<b>Reason for Referral</b>			
<b>Patient Goals:</b>			
<b>Caregiver Goals and Specific Limitations that May Effect Care:</b>			

## MEDICAL HISTORY:

<b>Primary Diagnosis:</b>	<b>Onset:</b>	
<b>Secondary Diagnoses :</b>		
<input type="checkbox"/> Progressive Disease	<b>Relevant Past and Future Surgeries:</b>	
<b>Height:</b>	<b>Weight:</b>	<b>Describe Changes Past 2-5 years – Include Seating Measurements If Relevant:</b>
<b>Cardio Status:</b> _____ <b>Functional Limitations:</b> _____		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Severely Impaired <input type="checkbox"/> NA		
<b>Respiratory Status:</b> _____ <b>Functional Limitations:</b> _____		
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Severely Impaired <input type="checkbox"/> NA		
<b>Orthotics:</b> _____ <b>Amputee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

## HOME ENVIRONMENT:

<input type="checkbox"/> House <input type="checkbox"/> Condo/Town Home <input type="checkbox"/> Apartment <input type="checkbox"/> Asst Living <input type="checkbox"/> LTCF <input type="checkbox"/> Own <input type="checkbox"/> Rent	
<input type="checkbox"/> Lives Alone <input type="checkbox"/> Lives with Others (Who?)	<b>Hours with caregiver:</b> _____
<input type="checkbox"/> Home is Accessible to Equipment <b>Storage of Wheelchair:</b> <input type="checkbox"/> In Home <input type="checkbox"/> Other <b>Stairs:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Comments:(Describe management of equipment if stairs present – Describe security of Storage if Other is Checked)</b>	

Patient Name:

**COMMUNITY ADL:**

<b>TRANSPORTATION:</b>	
<input type="checkbox"/> Car <input type="checkbox"/> Van <input type="checkbox"/> Public Transportation <input type="checkbox"/> Adapted W/C Lift <input type="checkbox"/> Ambulance <input type="checkbox"/> Other: <input type="checkbox"/> Sits in Wheelchair During Transport	
Where is W/C Stored During Transport? <input type="checkbox"/> Tie Downs	
<input type="checkbox"/> Self Driver Drive While in Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Employment:</b> Specific Requirements Pertaining to Mobility	
<b>School:</b> Specific Requirements Pertaining to Mobility	
<b>Other:</b>	

**FUNCTIONAL/SENSORY PROCESSING SKILLS:**

<b>Handedness:</b> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> NA Comments:
<b>Visual Acuity is Adequate For Safe Wheelchair Operation:</b> [ ] Yes [ ] No
<b>Processing Skills are Adequate for Safe Wheelchair Operation:</b> [ ] Yes [ ] No
<b>Comments – Describe Limitations:</b>

**COMMUNICATION:**

Verbal Communication <input type="checkbox"/> WFL Receptive <input type="checkbox"/> WFL Expressive <input type="checkbox"/> Understandable <input type="checkbox"/> Difficult to Understand <input type="checkbox"/> Non-Communicative
<input type="checkbox"/> Uses an Augmentative Communication Device Manufacturer/Model :
AAC Mount Needed:

**SENSATION and SKIN ISSUES:**

<b>Sensation</b> <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hyposensate <input type="checkbox"/> Hypersensate <input type="checkbox"/> Defensiveness Level of sensation:		<b>Pressure Relief:</b> Able to Perform Effective Pressure Relief : <input type="checkbox"/> Yes <input type="checkbox"/> No Method: If not, Why?:	
<b>Skin Issues/Skin Integrity</b> Current Skin Issues <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Intact <input type="checkbox"/> Red Area <input type="checkbox"/> Open Area <input type="checkbox"/> Scar Tissue <input type="checkbox"/> At Risk from Prolonged Sitting Where _____		History of Skin Issues <input type="checkbox"/> Yes <input type="checkbox"/> No Where _____ When _____	
		Hx of Skin Flap Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No Where _____ When _____	
<b>Complaint of Pain:</b> (Describe Location, Severity (Scale 1-10), Acute or Chronic, And How It Interferes With Ability To Operate Equip.)			

**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: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						Comments:
Bladder Mngmnt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Accidents						Comments:

Patient Name:

**CURRENT SEATING / MOBILITY:**

<b>Current Mobility Base:</b> <input type="checkbox"/> None <input type="checkbox"/> Dependent <input type="checkbox"/> Dependent with Tilt <input type="checkbox"/> Manual <input type="checkbox"/> Scooter <input type="checkbox"/> Power Type of Control:				
<b>Manufacturer:</b>		<b>Size:</b>	<b>Model:</b>	<b>Serial #:</b>
<b>Pediatric [ ] Adult [ ]</b>		<b>Color:</b>	<b>Age:</b>	
Current Condition of Mobility Base:				
Current Seating System:			Age of Seating System:	
<b>COMPONENT</b>		<b>MANUFACTURER/CONDITION</b>		
Seat Base				
Cushion				
Back				
Lateral Trunk Supports				
Thigh Support				
Knee Support				
Foot Support				
Foot Strap				
Head Support				
Pelvic Stabilization				
Anterior Chest/Shoulder Support				
UE Support				
Other (Tilt/Recline, etc.)				
When Relevant:	Overall Seat Height	Overall W/C Length	Overall W/C Width	
Describe Posture in Present Seating System:				
Number of Hours/Day Spent in Wheelchair?				

**WHEELCHAIR SKILLS: (Shown by Trial) PT. IS TOTALLY DEPENDENT FOR MOBILITY YES [ ] NO [ ]**

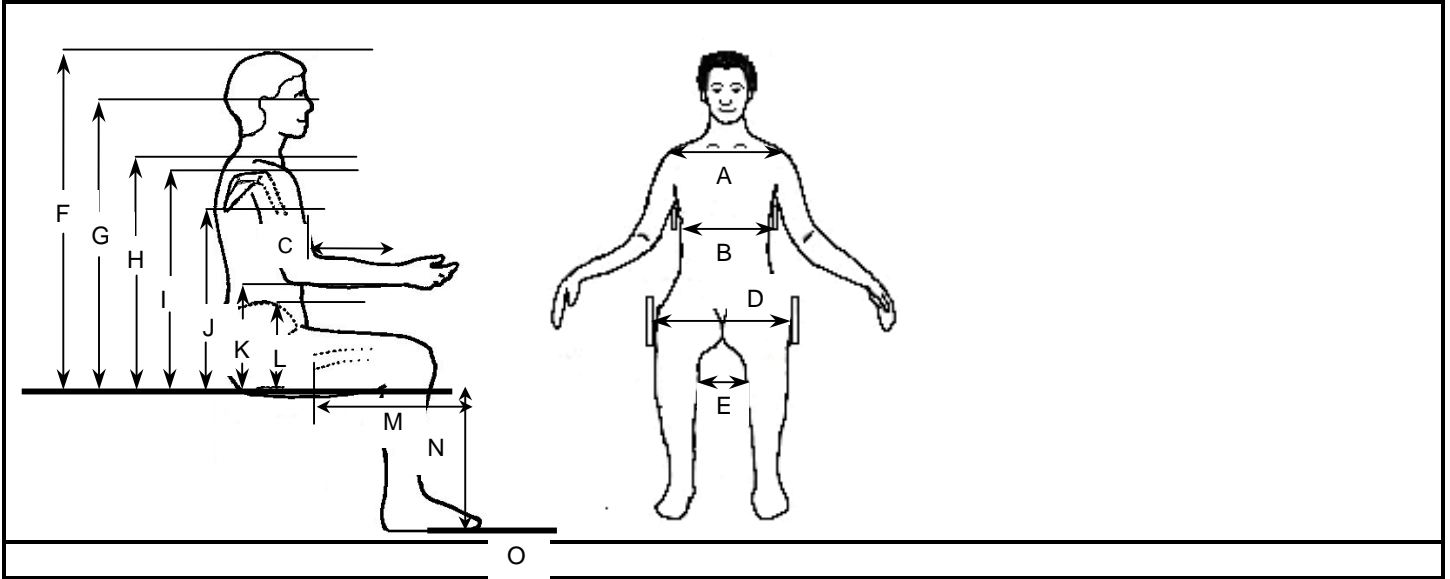
	Indep	Assist	Dependent/Unable	N/A	Comments
Bed ↔ W/C Chair Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
w/c ↔ Commode Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Manual w/c Propulsion:	<input type="checkbox"/> UE or LE Strength and Endurance Sufficient to Participate in ADLs Using Manual Wheelchair				Arm : <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both Foot: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Operate Scooter	<input type="checkbox"/> Strength, Hand Grip, Balance, Transfer Appropriate for Use. <input type="checkbox"/> Living Environment Appropriate for Scooter Use.				
Operate Power W/C: Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance
Operate Power W/C: w/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Safe <input type="checkbox"/> Functional Distance

**MOBILITY/BALANCE:**

<b>Balance</b>		<b>Transfers</b>	<b>Ambulation</b>
Sitting Balance:	Standing Balance	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent
<input type="checkbox"/> WFL	<input type="checkbox"/> WFL	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Ambulates with Asst
<input type="checkbox"/> Uses UE for Balance in Sitting	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Mod Asst	<input type="checkbox"/> Ambulates with Device
<input type="checkbox"/> Min Assist	<input type="checkbox"/> Mod Assist	<input type="checkbox"/> Max Assist	<input type="checkbox"/> Indep. Short Distance Only
<input type="checkbox"/> Mod Assist	<input type="checkbox"/> Max Assist	<input type="checkbox"/> Dependent	<input type="checkbox"/> Unable to Ambulate
<input type="checkbox"/> Max Assist	<input type="checkbox"/> Unable	<input type="checkbox"/> Sliding Board	
<input type="checkbox"/> Unable		<input type="checkbox"/> Lift / Sling Required	
<b>Comments:</b>			

Patient Name:

**MAT EVALUATION:**



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









Additional Comments:

Hamstring flexibility: Pelvis to thigh angle  accommodate greater than 90 Thigh to calf angle  accommodate less than 90

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

EXPLAIN WHY PATIENT IS NON-AMBULATORY:

Patient Name:

POSTURE:			COMMENTS:
<b>P E L V I S</b>	<b>Anterior / Posterior</b>	<b>Obliquity</b>	<b>Rotation-Pelvis</b>
	 <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	 <input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> L elev  <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	 <input type="checkbox"/> WFL <input type="checkbox"/> Right Anterior <input type="checkbox"/> Left Anterior  <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible
<b>T R U N K</b>	<b>Anterior / Posterior</b>	<b>Left Right</b>	<b>Rotation-shoulders and upper trunk</b>
	 <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	 <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right <input type="checkbox"/> c-curve <input type="checkbox"/> s-curve <input type="checkbox"/> multiple <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	 <input type="checkbox"/> Neutral <input type="checkbox"/> Left-anterior <input type="checkbox"/> Right-anterior <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other
<b>Describe LE Neurological Influence/Tone:</b>			
<b>H I P S</b>	<b>Position</b>	<b>Windswept</b>	<b>Hip Flexion/Extension Limitations:</b>
	 <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	 <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	<b>Hip Internal/External Range of motion Limitations:</b>
<b>K N E E S &amp; F E E T</b>	<b>Knee R.O.M.</b>		<b>Foot Positioning</b>
	Left                      Right <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Limitations <input type="checkbox"/> Limitations		<input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R ROM concerns: Dorsi-Flexed <input type="checkbox"/> L <input type="checkbox"/> R Plantar Flexed <input type="checkbox"/> L <input type="checkbox"/> R Inversion <input type="checkbox"/> L <input type="checkbox"/> R Eversion <input type="checkbox"/> L <input type="checkbox"/> R

Patient Name:

POSTURE:			COMMENTS:
<b>HEAD &amp; NECK</b>	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated L <input type="checkbox"/> Lat Flexed L <input type="checkbox"/> Rotated R <input type="checkbox"/> Lat Flexed R <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	Describe Tone/Movement of head and Neck:
<b>U P P E R E X T R E M I T Y</b>	<b>SHOULDERS</b>		Describe Tone/Movement of UE:
	<b>Left</b> <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract  <input type="checkbox"/> subluxed	<b>Right</b> <input type="checkbox"/> Functional <input type="checkbox"/> elev / dep <input type="checkbox"/> pro-retract  <input type="checkbox"/> subluxed	
	<b>ELBOWS</b>		
	<b>Left</b>	<b>Right</b>	<b>R.O.M. Strength (X/5)</b> <b>Strength concerns:</b>
<b>WRIST &amp; HAND</b>	<b>Left</b>	<b>Right</b>	<b>Strength / Dexterity: (X/5)</b>
	<input type="checkbox"/> Fisting		

**Goals for Wheelchair Mobility**

- Independence with mobility in the home and mobility related ADLs (MRADLs) in the community
- Independence with MRADLs in the community
- Provide dependent mobility
- Provide recline
- Provide tilt

**Goals for Seating system**

- Optimize pressure distribution
- Provide support needed to facilitate function or safety
- Provide corrective forces to assist with maintaining or improving posture
- Accommodate client's posture: current seated postures and positions are not flexible or will not tolerate corrective forces
- Client to be independent with relieving pressure in the wheelchair
- Enhance physiological function such as breathing, swallowing, digestion

**Equipment Trial: (Must be of adequate duration to demonstrate independence for patient with previous dependent mobility.)**

**Describe Duration and Location of Trial:** \_\_\_\_\_

**Patient Demonstrated Ability To Use Equipment Safely & Efficiently [ ] Yes [ ] No Comments:** \_\_\_\_\_

**State why other equipment was unsuccessful:** \_\_\_\_\_

Patient Name:

**RECOMMENDATIONS & JUSTIFICATION (Lowest Appropriate Group Must Be Recommended)**

MOBILITY BASE	JUSTIFICATION	
<b>Mfgr:</b> _____ <b>Model:</b> _____ Seat Width _____ Seat Depth _____ <b>Can Be Grown To: (Must Complete)</b> Seat Width _____ Seat Depth _____	<input type="checkbox"/> provide transport from point A to B <input type="checkbox"/> promote Indep mobility <input type="checkbox"/> is not a safe, functional ambulator <input type="checkbox"/> walker or cane inadequate	<input type="checkbox"/> non-standard width/depth necessary to accommodate anatomical measurement <input type="checkbox"/>
<input type="checkbox"/> <b>Manual Mobility Base</b>	<input type="checkbox"/> non-functional ambulator	
<input type="checkbox"/> <b>Scooter/POV</b>	<input type="checkbox"/> can safely operate <input type="checkbox"/> can safely transfer	<input type="checkbox"/> has adequate trunk stability <input type="checkbox"/> can not functionally propel manual wheelchair
<input type="checkbox"/> <b>Power Mobility Base</b>	<input type="checkbox"/> non-ambulatory <input type="checkbox"/> can not functionally propel manual wheelchair	<input type="checkbox"/> can not functionally and safely operate scooter/POV
<input type="checkbox"/> <b>Stroller Base</b>	<input type="checkbox"/> infant/child <input type="checkbox"/> unable to propel manual wheelchair <input type="checkbox"/> allows for growth	<input type="checkbox"/> non-functional ambulator <input type="checkbox"/> non-functional UE <input type="checkbox"/> Indep mobility is not a goal at this time
<b>Reasons This Particular WC Was Chosen for Patient?</b> _____ _____		
<b>Why Isn't a Lower Group Appropriate for Patient?</b> _____ _____		
<b>Tilt Base or added</b> <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Powered tilt on powered chair <input type="checkbox"/> Powered tilt on manual chair <input type="checkbox"/> Manual tilt on manual base	<input type="checkbox"/> change position against gravitational force on head and shoulders <input type="checkbox"/> change position for pressure relief/can not weight shift <input type="checkbox"/> transfers	<input type="checkbox"/> management of tone <input type="checkbox"/> rest periods <input type="checkbox"/> control edema <input type="checkbox"/> facilitate postural control <input type="checkbox"/>
<b>Recline</b> <input type="checkbox"/> Power recline on power base <input type="checkbox"/> Manual recline on manual base	<input type="checkbox"/> accommodate femur to back angle <input type="checkbox"/> bring to full recline for ADL care <input type="checkbox"/> change position for pressure relief/can not weight shift	<input type="checkbox"/> rest periods <input type="checkbox"/> repositioning for transfers or clothing/diaper /catheter changes <input type="checkbox"/> head positioning
<input type="checkbox"/> <b>Transportation tie-down option</b>	<input type="checkbox"/> to provide crash tested tie down brackets	
<b>Elevator on Mobility Base</b> <input type="checkbox"/> Wheelchair <input type="checkbox"/> Scooter	<input type="checkbox"/> increase Indep in transfers <input type="checkbox"/> increase Indep in ADLs	<input type="checkbox"/> raise height for communication at standing level <input type="checkbox"/>
<b>Push handles</b> <input type="checkbox"/> extended <input type="checkbox"/> angle adjustable <input type="checkbox"/> standard	<input type="checkbox"/> caregiver access <input type="checkbox"/> caregiver assist	<input type="checkbox"/> allows "hooking" to enable increased ability to perform ADLs or maintain balance
<input type="checkbox"/> <b>Lighter weight required</b>	<input type="checkbox"/> self propulsion <input type="checkbox"/> lifting	<input type="checkbox"/>
<input type="checkbox"/> <b>Heavy Duty required</b>	<input type="checkbox"/> user weight greater than 250 pounds <input type="checkbox"/> extreme tone <input type="checkbox"/> over active movement	<input type="checkbox"/> broken frame on previous chair <input type="checkbox"/> multiple seat functions <input type="checkbox"/>
<input type="checkbox"/> <b>Specific seat height required</b> Floor to seat height	<input type="checkbox"/> foot propulsion <input type="checkbox"/> transfers <input type="checkbox"/> accommodation of leg length	<input type="checkbox"/> access to table or desk top <input type="checkbox"/>

Patient Name:

MOBILITY BASE	JUSTIFICATION	
<p><b>Rear wheel placement/Axle adjustability</b>  <input type="checkbox"/>None <input type="checkbox"/>semi adjustable <input type="checkbox"/>fully adjustable</p>	<input type="checkbox"/> improved UE access to wheels <input type="checkbox"/> improved stability <input type="checkbox"/> changing angle in space for improvement of postural stability	<input type="checkbox"/> 1-arm drive access <input type="checkbox"/> amputee placement <input type="checkbox"/>
<p><b>Angle Adjustable Back</b></p>	<input type="checkbox"/> postural control <input type="checkbox"/> control of tone/spasticity <input type="checkbox"/> accommodation of range of motion	<input type="checkbox"/> UE functional control <input type="checkbox"/> accommodation for seating system <input type="checkbox"/>
<p><b>POWER WHEELCHAIR CONTROLS</b>  <input type="checkbox"/>Proportional            Type            Body Parts            Left Right  <input type="checkbox"/>Non-Proportional/switches            Type            Body Parts    <b>Upgraded Electronics</b>  <input type="checkbox"/>    <input type="checkbox"/>Display box    <input type="checkbox"/>Digital interface electronics    <input type="checkbox"/>ASL Head Array    <input type="checkbox"/>Sip and puff tubing kit    <input type="checkbox"/>Upgraded tracking electronics    <input type="checkbox"/>Safety Reset Switches    <input type="checkbox"/>Single or Multiple Actuator Control Module</p>	<input type="checkbox"/> provides access for controlling wheelchair  <input type="checkbox"/> lacks motor control to operate proportional drive control <input type="checkbox"/> unable to understand proportional controls  <input type="checkbox"/> programming for accurate control <input type="checkbox"/> progressive Disease/changing condition <input type="checkbox"/> Needed in order to operate power/tilt through joystick control  <input type="checkbox"/> Allows user to see in which mode and drive the wheelchair is set; necessary for alternate controls  <input type="checkbox"/> Allows w/c to operate when using alternative drive controls  <input type="checkbox"/> Allows client to operate wheelchair through switches placed in tri-panel headrest  <input type="checkbox"/> needed to operate sip and puff drive controls  <input type="checkbox"/> increase safety when driving <input type="checkbox"/> correct tracking when on uneven surfaces  <input type="checkbox"/> Used to change modes and stop the wheelchair when driving in latch mode  <input type="checkbox"/> Allow the client to operate the power seat function(s) through the joystick control	<p><b>If Expandable Controller Recommended Provide Additional Narrative In Space At End Of Form re Why Patient Requires Expandable Controller vs. Non –Expandable Controller</b></p> <input type="checkbox"/> non-proportional drive control needed (Explain)



Patient Name:

MOBILITY BASE	JUSTIFICATION	
<input type="checkbox"/> Mount for switches or joystick	<input type="checkbox"/> attaches switches to w/c <input type="checkbox"/> Swing away for access or transfers	<input type="checkbox"/> midline for optimal placement <input type="checkbox"/> provides for consistent access
<b>Attendant controlled joystick plus mount</b>	<input type="checkbox"/> safety <input type="checkbox"/> long distance driving <input type="checkbox"/> operation of seat functions	<input type="checkbox"/> compliance with transportation regulations <input type="checkbox"/>
<b>Battery</b>	<input type="checkbox"/> power motor on wheelchair	
<b>Charger</b>	<input type="checkbox"/> charge battery for wheelchair	
<b>Push rim active assist</b>	<input type="checkbox"/> enable propulsion of manual wheelchair on sloped terrain	<input type="checkbox"/> enable propulsion of manual wheelchair for distance
<b>Hangers/ Leg rests</b> <input type="checkbox"/> 60 <input type="checkbox"/> 70 <input type="checkbox"/> 90 <input type="checkbox"/> elevating <input type="checkbox"/> heavy duty <input type="checkbox"/> articulating <input type="checkbox"/> fixed <input type="checkbox"/> lift off <input type="checkbox"/> swing away <input type="checkbox"/> rotational hanger brackets <input type="checkbox"/> adjustable knee angle <input type="checkbox"/> adjustable calf panel <input type="checkbox"/> Longer extension tube	<input type="checkbox"/> provide LE support <input type="checkbox"/> accommodate to hamstring tightness <input type="checkbox"/> elevate legs during recline <input type="checkbox"/> provide change in position for Les <input type="checkbox"/> maintain placement of feet on footplate	<input type="checkbox"/> durability <input type="checkbox"/> enable transfers <input type="checkbox"/> decrease edema <input type="checkbox"/> Accommodate lower leg length <input type="checkbox"/>
<b>Foot support</b> <input type="checkbox"/> adjustable Footplate <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> flip up <input type="checkbox"/> depth/angle adjustable	<input type="checkbox"/> provide foot support <input type="checkbox"/> accommodate to ankle ROM <input type="checkbox"/> allow foot to go under wheelchair base	<input type="checkbox"/> transfers <input type="checkbox"/>
<b>Armrests</b> <input type="checkbox"/> fixed <input type="checkbox"/> adjustable height <input type="checkbox"/> removable <input type="checkbox"/> swing away <input type="checkbox"/> flip back <input type="checkbox"/> reclining <input type="checkbox"/> full length pads <input type="checkbox"/> desk <input type="checkbox"/> pads tubular	<input type="checkbox"/> provide support with elbow at 90 <input type="checkbox"/> provide support for w/c tray <input type="checkbox"/> change of height/angles for variable activities	<input type="checkbox"/> remove for transfers <input type="checkbox"/> allow to come closer to table top <input type="checkbox"/> remove for access to tables <input type="checkbox"/>
<b>Side guards</b>	<input type="checkbox"/> prevent clothing getting caught in wheel or becoming soiled	
<b>Wheel size:</b> <b>Wheel Style</b> <input type="checkbox"/> mag <input type="checkbox"/> spokes <input type="checkbox"/>	<input type="checkbox"/> increase access to wheel <input type="checkbox"/> allow for seating system to fit on base	<input type="checkbox"/> increase propulsion ability <input type="checkbox"/> maintenance <input type="checkbox"/>
<b>Quick Release Wheels</b>	<input type="checkbox"/> allows wheels to be removed to decrease width of w/c for storage	<input type="checkbox"/> decrease weight for lifting <input type="checkbox"/>
<b>Wheel rims/ hand rims</b> <input type="checkbox"/> metal <input type="checkbox"/> plastic coated <input type="checkbox"/> vertical projections <input type="checkbox"/> oblique projections	<input type="checkbox"/> provide ability to propel manual wheelchair	<input type="checkbox"/> increase self-propulsion with hand weakness/decreased grasp
<b>Tires:</b> <input type="checkbox"/> pneumatic <input type="checkbox"/> flat free inserts <input type="checkbox"/> solid	<input type="checkbox"/> decrease maintenance <input type="checkbox"/> prevent frequent flats <input type="checkbox"/> increase shock absorbency	<input type="checkbox"/> decrease pain from road shock <input type="checkbox"/> decrease spasms from road shock <input type="checkbox"/>
<b>Caster housing:</b> <b>Caster size:</b> <b>Style:</b>	<input type="checkbox"/> maneuverability <input type="checkbox"/> stability of wheelchair <input type="checkbox"/> increase shock absorbency <input type="checkbox"/> durability <input type="checkbox"/> maintenance <input type="checkbox"/> angle adjustment for posture	<input type="checkbox"/> decrease pain from road shock <input type="checkbox"/> decrease spasms from road shock <input type="checkbox"/> allow for feet to come under wheelchair base <input type="checkbox"/> allows change in seat to floor height <input type="checkbox"/>
<b>Shock absorbers</b>	<input type="checkbox"/> decrease vibration	<input type="checkbox"/> provide smoother ride over rough terrain
<b>Spoke Protector</b>	<input type="checkbox"/> prevent hands from getting caught in spokes	<input type="checkbox"/>

Patient Name:

One armed device <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> enable propulsion of manual wheelchair with one arm	<input type="checkbox"/>
Anti-tippers	<input type="checkbox"/> prevent wheelchair from tipping backward	<input type="checkbox"/>
Amputee adapter	<input type="checkbox"/> provide support for stump/residual extremity	
<input type="checkbox"/> Crutch/cane holder <input type="checkbox"/> Oxygen Cylinder holder <input type="checkbox"/> IV hanger	<input type="checkbox"/> stabilize accessory on wheelchair	
Brake/wheel lock extension <input type="checkbox"/> R <input type="checkbox"/> L		<input type="checkbox"/> increase indep in applying wheel locks
Other:		
Other:		

### SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manuf/mod/size	Justification	
<b>Seat Cushion</b>		<input type="checkbox"/> accommodate impaired sensation <input type="checkbox"/> decubitus ulcers present <input type="checkbox"/> prevent pelvic extension <input type="checkbox"/> low maintenance	<input type="checkbox"/> stabilize pelvis <input type="checkbox"/> accommodate obliquity <input type="checkbox"/> accommodate multiple deformity <input type="checkbox"/> neutralize LE <input type="checkbox"/> increase pressure distribution <input type="checkbox"/>
<b>Seat Wedge</b>		<input type="checkbox"/> accommodate ROM	<input type="checkbox"/> Provide increased aggressiveness of seat shape to decrease sliding down in the seat
<b>Cover Replacement</b>		<input type="checkbox"/> protect back or seat cushion	<input type="checkbox"/>
<b>Mounting hardware</b> lateral trunk supports headrest medial thigh support back seat	fixed  swing away for:	<input type="checkbox"/> attach seat platform/cushion to w/c frame <input type="checkbox"/> attach back cushion to w/c frame	<input type="checkbox"/> mount headrest <input type="checkbox"/> swing medial thigh support away <input type="checkbox"/> swing lateral supports away for transfers
<b>Seat Board Back Board</b>		<input type="checkbox"/> support cushion to prevent hammocking	<input type="checkbox"/> allows attachment of cushion to mobility base
<b>Back</b>		<input type="checkbox"/> provide lateral trunk support <input type="checkbox"/> accommodate deformity <input type="checkbox"/> accommodate or decrease tone <input type="checkbox"/> facilitate tone	<input type="checkbox"/> provide posterior trunk support <input type="checkbox"/> provide lumbar/sacral support <input type="checkbox"/> support trunk in midline <input type="checkbox"/>
<b>Lateral pelvic/thigh support</b>		<input type="checkbox"/> pelvis in neutral <input type="checkbox"/> accommodate pelvis <input type="checkbox"/> position upper legs	<input type="checkbox"/> accommodate tone <input type="checkbox"/> removable for transfers <input type="checkbox"/>
<b>Medial Knee Support</b>		<input type="checkbox"/> decrease adduction <input type="checkbox"/> accommodate ROM	<input type="checkbox"/> remove for transfers <input type="checkbox"/> alignment
<b>Foot Support</b>		<input type="checkbox"/> position foot <input type="checkbox"/> accommodate deformity	<input type="checkbox"/> stability <input type="checkbox"/> decrease tone <input type="checkbox"/> control position
<b>Ankle strap/heel loops</b>		<input type="checkbox"/> support foot on foot support <input type="checkbox"/> decrease extraneous	<input type="checkbox"/> provide input to heel <input type="checkbox"/> protect foot



