



# Clinical Information for Wheeled Mobility

## PART A: PATIENT / PROVIDER INFORMATION - Please Print

Name: \_\_\_\_\_ Sponsor Soc. Sec. No: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Date Referred: \_\_\_\_\_ Date of Eval: \_\_\_\_\_ Physician: \_\_\_\_\_  
 OT: \_\_\_\_\_ PT: \_\_\_\_\_  
 Referred By: \_\_\_\_\_  
 Reason for Referral: \_\_\_\_\_

Patient Goals: \_\_\_\_\_

Caregiver Goals: \_\_\_\_\_

## PART B: MEDICAL HISTORY

Dx: \_\_\_\_\_ ICD-9: \_\_\_\_\_ ICD-9: \_\_\_\_\_  
 \_\_\_\_\_ ICD-9: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Hx / Progression: \_\_\_\_\_

Recent / Planned Surgeries: \_\_\_\_\_

Cardio-Respiratory Status:    Intact    Impaired

Comments: \_\_\_\_\_

## PART C: CURRENT SEATING / MOBILITY: (Type - Manufacturer - Model)

Chair: \_\_\_\_\_ Age: \_\_\_\_\_

w/c Cushion: \_\_\_\_\_ Age: \_\_\_\_\_ w/c Back: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for:    Replacement    Repair    Update    \_\_\_\_\_

Funding Source: \_\_\_\_\_

## PART D: 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: \_\_\_\_\_

## PART E: COMMUNITY ADL

TRANSPORTATION:    Car    Van    Bus    ADAPTED WITH:    Chair Lift    Ramp    Ambulance    Other\*

Driving Requirements: \_\_\_\_\_

Employment / Educational Requirements: \_\_\_\_\_

\*Other: \_\_\_\_\_

**PART F: COGNITIVE / VISUAL STATUS** (Please check appropriate box and make comments as needed)

	Intact	Impaired	Comments
Memory Skills			
Problem Solving			
Judgment			
Attention / Concentration			
Vision			
Hearing			
Other			

**PART G: ADL STATUS** (Please check appropriate box and make comments as needed)

	INDEP	ASSIST	UNABLE	Comments / Other AT Equipment Required
Dressing				
Bathing				
Feeding				
Grooming/Hygiene				
Toileting				
Meal Prep				
Home Management				
Bowel Management	Continent		Incontinent	
Bladder Management	Continent		Incontinent	

**PART H: MOBILITY SKILLS** (Please check appropriate box and make comments as needed)

	INDEP	ASSIST	UNABLE	N/A	COMMENTS
Bed $\longleftrightarrow$ w/c Transfers					
w/c $\longleftrightarrow$ Commode Transfers					
Ambulation					Device:
Manual w/c Propulsion					
Operate Power w/c w/ Std. Joystick					
Operate Power w/c w/ Alternative Controls					
Able to Perform Weight Shifts					Type:
Hours Spent Sitting in w/c Each Day:	Comments:				

**PART I: SENSATION**

Intact	Impaired	Absent
Hx of Pressure Sores	Yes	No
Current Pressure Sores	Yes	No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PART J: CLINICAL CRITERIA / ALGORITHM SUMMARY**

	YES	NO	N/A
1. 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?			
<b>Explain:</b>			
2. Are there cognitive or sensory deficits (awareness / judgment / vision / etc) that limit the user's ability to safely participate in one or more MRADL's / ADL's?			
If yes, can they be accomodated / compensated for to allow use of a mobility assistive device to participate in MRADL's?			
<b>Explain:</b>			
3. Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device?			
<b>Explain:</b>			
4. Can the mobility deficit be sufficiently resolved with only the use of a cane or walker?			
<b>Explain:</b>			
5. Does the user's environment support the use of a: MANUAL WHEELCHAIR                  POV                  POWER WHEELCHAIR			
<b>Explain:</b>			
6. If a manual wheelchair is recommended, does the user have sufficient function / abilities to use the recommended equipment?			
<b>Explain:</b>			
7. If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it?			
<b>Explain:</b>			
8. If a power wheelchair is recommended, does the user have sufficient function / abilities to use the recommended equipment?			
<b>Explain:</b>			

**PART K: RECOMMENDATIONS / GOALS**

- MANUAL WHEELCHAIR
- POV
- POWER WHEELCHAIR
- POSITIONING SYSTEM (TILT/RECLINE/ELEV/STANDING)
- SEATING

**MAT EVALUATION: SITTING OR SUPINE**

**HEAD & NECK**

**POSTURE:**

Functional	Flexed
Extended	Rotated
Laterally Flexed	Cervical Hyperextension

**FUNCTION:**

Good Head Control	Adequate Head Control
Limited Head Control	Absent Head Control

**Support Needed:** \_\_\_\_\_

Comments: \_\_\_\_\_

**UPPER EXTREMITY**

**SHOULDERS:**

	Left	Right
WFL	_____	_____
Elev/dep	_____	_____
Pro/retract	_____	_____
Subluxed	_____	_____

Range of Motion (R.O.M.): \_\_\_\_\_

Strength: \_\_\_\_\_

**Support Needed:** \_\_\_\_\_

Comments: \_\_\_\_\_

**ELBOWS:**

	Left	Right
Impaired	_____	_____
WFL	_____	_____

Range of Motion (R.O.M.): \_\_\_\_\_

Strength: \_\_\_\_\_

**Support Needed:** \_\_\_\_\_

Comments: \_\_\_\_\_

**WRIST & HAND**

	Left	Right
Impaired	_____	_____
WFL	_____	_____

Strength/Dexterity: \_\_\_\_\_

**Support Needed:** \_\_\_\_\_

Comments: \_\_\_\_\_

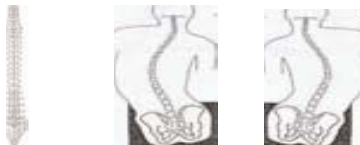
**TRUNK**

**Anterior / Posterior**



WFL	↑ Thoracic Kyphosis	↑ Lumbar Lordosis
Fixed	Flexible	Flexible
Partly Flexible	Other	Other

**Left / Right**



WFL	Convex Left	Convex Right
Fixed	Flexible	Flexible
Partly Flexible	Other	Other

**Rotation**



- Neutral
- Left Forward
- Right Forward

Fixed	Flexible
Partly Flexible	Other

**Support Needed:** \_\_\_\_\_

**MAT EVALUATION:** (Continued)

**PELVIS**

**ANTERIOR / POSTERIOR**



Neutral  
Fixed  
Partly Flexible

Posterior  
Flexible  
Other

Anterior

**OBLIQUITY**

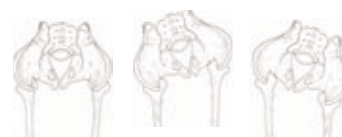


WFL  
Fixed  
Partly Flexible

Left Lower  
Flexible  
Other

Rt. Lower

**ROTATION**



WFL  
Fixed  
Partly Flexible

Right  
Flexible  
Other

Left

**Support Needed:** \_\_\_\_\_

**HIPS**

**POSITION**



Neutral  
Fixed  
Partly Flexible  
Flexible

ABduct  
Subluxed  
Dislocated

ADduct

**WINDSWEPT**



Neutral  
Fixed  
Flexible

Right  
Partly Flexible  
Other

Left

**RANGE OF MOTION**



Left  
Flex: \_\_\_\_\_°  
Ext: \_\_\_\_\_°  
Int R: \_\_\_\_\_°  
Ext R: \_\_\_\_\_°

Right  
Flex: \_\_\_\_\_°  
Ext: \_\_\_\_\_°  
Int R: \_\_\_\_\_°  
Ext R: \_\_\_\_\_°

**KNEES & FEET**

**KNEE R.O.M.**

**LEFT**

**RIGHT**

WFL

WFL

Flex \_\_\_\_\_°

Flex \_\_\_\_\_°

Ext \_\_\_\_\_°

Ext \_\_\_\_\_°

Strength: \_\_\_\_\_

Hamstring R.O.M. Limitations: (Measured at \_\_\_\_o Hip Flex)

Left \_\_\_\_\_ Right \_\_\_\_\_

**FOOT POSITIONING**

**LEFT**

**RIGHT**

WFL

WFL

Dorsi-Flexed

Dorsi-Flexed

Plantar Flexed

Plantar Flexed

Inversion

Inversion

Eversion

Eversion

Foot Positioning Needs: \_\_\_\_\_

**MOBILITY**

**BALANCE**

Sitting Balance

Standing Balance

WFL

WFL

Min Support

Min Support

Mod Support

Mod Support

Unable

Unable

**TRANSFERS**

Independent

Min Assist

Max Assist

Sliding Board

Lift / Sling Required

**AMBULATION**

Unable to Ambulate

Ambulates with Assistance

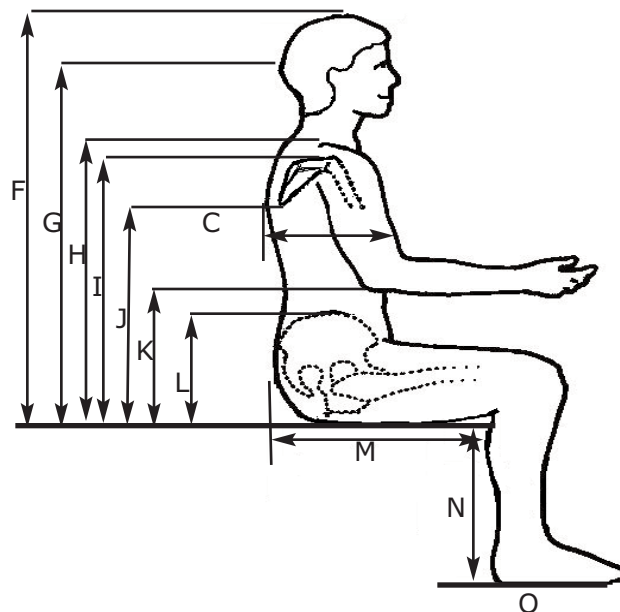
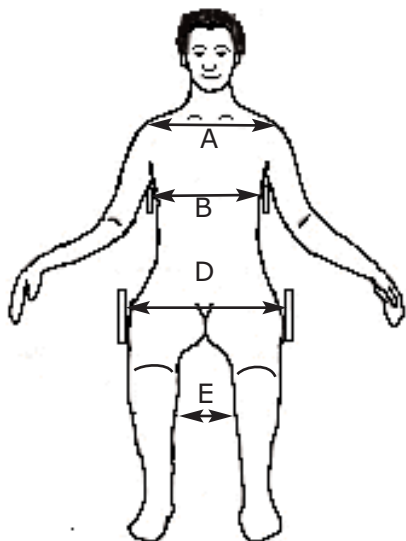
Ambulates with Device

Independent without Device

Indep. Short Distance Only

**MAT EVALUATION:** (Continued)

**MEASUREMENTS**



Measurements in Sitting:	
<b>A</b>	Shoulder Width
<b>B</b>	Chest Width
<b>C</b>	Chest Depth (Front - Back)
<b>D</b>	Asymmetrical Hip Width**
<b>D</b>	Hip Width
<b>E</b>	Between Knees
<b>F</b>	Top of Head
<b>G</b>	Occiput

\*\* Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point

Right	Left	
		Degree of Hip Flexion
	<b>H</b>	Top of Shoulder
	<b>I</b>	Acromion Process (Tip of Shoulder)
	<b>J</b>	Inferior Angle of Scapula
	<b>K</b>	Elbow
	<b>L</b>	Iliac Crest
	<b>M</b>	Sacrum to Popliteal Fossa
	<b>N</b>	Knee to Heel
	<b>O</b>	Foot Length

**Neuro-Muscular Status:**

Tone: \_\_\_\_\_

Reflexive Responses: \_\_\_\_\_

Effect on Function: \_\_\_\_\_

**Additional Comments:** \_\_\_\_\_

Physical / Occupational Therapist: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Physician Signature: (I have read and concur with the above assessment) \_\_\_\_\_

Date: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

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