Wheelchair Assessment

Introduction

Districts choose the assessment tools that they feel are appropriate for the students served. However, depending on circumstances and funding source, there may be mandates concerning the choice of wheelchair assessment that must be used. This evaluation tool was created in collaboration with OT/PTs in Florida’s school system. For additional information about wheelchair assessment, see Gierach (2009).

Instructions

This assessment is used when a student is being evaluated regarding his/her current wheelchair and possible modifications. It is also used when evaluating a student for a new wheelchair.

Whenever possible, this assessment should be completed as part of a team. Team members should include the therapist, the rehabilitation technology specialist (RTS)/wheelchair vendor, and the student’s parent(s) as well as any other person qualified to give input.

In addition to evaluating the wheelchair, there is a section designated to evaluate the student’s body as it pertains to the wheelchair. The team should consider the adaptations needed and the medical necessity for each component part of the wheelchair. It is very important that each section be completed fully and have details given for each custom modification and medical necessity.

I. Identifying Information:

- The information concerning the student’s demographics, medical condition, and diagnosis should be filled out completely.
- Under “Summary of Needs,” provide a detailed description of the child and the reason for needing a custom wheelchair. Include information regarding prognosis, ambulation potential, and overall use of a wheelchair.
- Be sure to document any orthopedic surgeries the student has received that will affect positioning.
- Whenever possible, consider attaching a picture of the student.

II. Wheelchair Use:

It is important to note where the wheelchair is used and how it is transported. It is also important to note if the current wheelchair frame or any component of the seating system can be used again.

III. Musculoskeletal Status:

A. Pelvis/Hips

Evaluate the pelvis and the tilt the pelvis is usually in while sitting. Also note pelvic obliquity and whether one side is higher or more forward.
Measure thigh length, being sure that the student is sitting upright. Also note the position of the lower extremities and whether there appears to be hip dislocation(s).

It is critical that in each section you note all custom modifications and why they are medical necessities.

Consider the following:

- **Solid Seat:**
  - **Reasons**
    - Provides a firm base of support.
    - Provides a base for symmetrical sitting.
    - Provides a central point from which to align the pelvis and trunk.
    - Facilitates balance capabilities.
    - Helps to minimize pelvic obliquity.
    - Positions lower extremities in more neutral position.
  - **Considerations**
    - Seat length must be accurate to provide for neutral alignment of the pelvis.
    - Seat must be firm enough to provide stability and the covering surface must be sufficient to provide comfort and pressure relief.

- **Hip Positioning:**
  - **Reasons**
    - Provides for symmetry of the hips.
    - Positions the pelvis for stability.
    - Allows for symmetrical weight bearing and discourages scoliosis, pelvic tilts, and/or dislocated hips.
  - **Considerations**
    - Degree of hip flexion must accommodate for fixed deformities and provide for best trunk alignment.
    - Seat to back angle should be 87–88 degrees of hip flexion.
    - Bilateral hip guides provide symmetrical alignment.

- **Split Length Seat:**
  - **Reasons**
    - Allows proper support of each lower extremity when there is a difference in leg length in the thigh area.
    - Supports longer leg to align it in neutral instead of adduction and internal rotation.
  - **Considerations**
    - If the leg length discrepancy is greater than one inch, accommodate for the difference.

- **Positioning Belt:**
  - **Reasons**
    - Aids in pelvic stability
    - Allows for trunk balance
  - **Considerations**
- Analyze the angle and directional pull of the positioning belt.
- Size of webbing and closure should be proportional to the size of the student.
- For students who ride the school bus, the type of closure may need to be a positive locking closure.
- Assess need for padding under the positioning belt.

B. Skin

Establish whether the student has any loss of sensation through testing or parent report. Determine if the student had a skin breakdown.

• Specialized Cushion:
  o Reasons
    ▪ Evens distribution of sitting pressure resulting in improved circulation.
    ▪ Minimizes potential for skin breakdown.
  o Considerations:
    ▪ Appraise the type and density of cushion material.
    ▪ Plan for the need for protective waterproof covering.
    ▪ Identify the extent of maintenance and care of cushion.

C. Trunk/Head

Evaluate the spine, noting any curves present. Note what occurs when the student is tired. Evaluate the student’s head control. Consider the following:

• Solid Back:
  o Reasons
    ▪ Helps to properly align the trunk and upper extremities to maximize head function and help prevent deformities.
    ▪ Minimizes posterior pelvic tilt.
  o Considerations
    ▪ Sufficient foam can provide comfort, pressure relief, and stability.
    ▪ Additional foam might be needed to support fixed deformities.

• Lateral Trunk Supports
  o Reasons
    ▪ To decrease excessive trunk mobility.
    ▪ To align the trunk, maintain symmetry, and discourage spinal deformity.
  o Considerations
    ▪ Use lateral supports on both sides of the student’s trunk.
    ▪ Allow room for chest expansion and some trunk movement.
    ▪ Do not cut into axilla.
    ▪ Removable or swing away supports are important for transfers.

• Tilt in Space System
  o Reasons
    ▪ Student with low tone cannot remain in an upright sitting position against gravity for any length of time.
- Student unable to reposition self to change pressure points.
- Tilt decreases the effects of gravity and thus assists in trunk alignment, prevents hanging of shoulder harness, and assists in positioning of head.

  o Considerations
  - Degree of tilt in space needs to be carefully evaluated for each student, with consideration of their muscle tone.

- **Harness System and Strap Guides:**
  - **Reasons**
    - Provides symmetrical trunk support.
    - Helps prevent forward trunk flexion.
  - **Considerations**
    - Type of harness must be evaluated on an individual basis.
    - Shoulder strap should pass over the shoulder and insert at a point directly at or slightly below the shoulder line.
    - Harness must attach to a second lower strap and not to the pelvic positioning strap.
    - Dynamic straps allow for some movement.
    - Strap guides assist in keeping straps on the student’s shoulders.

- **Head Control System:**
  - **Reasons**
    - Keeps the head and neck in functional chin tuck position where the head is supported on a neutrally aligned neck and eyes are held in a parallel plane to the floor.
  - **Considerations**
    - Maintain head in neutral alignment.
    - Use a head control system or extended back to assist in minimizing possible whiplash injuries during transportation.
    - Student may need a custom contoured system to allow for room at the ears and no interfere with vision.

- **D. Lower Extremities**

  Evaluate the tone in the lower extremities in regard to type and predominant movements. Evaluate the range of motion and patterns of movement that interfere with positioning. Measure the lower lengths of each extremity. Consider the following:

- **Medial Knee Support:**
  - **Reasons**
    - To maintain the lower extremities in neutral alignment and discourage adduction and internal rotation.
    - To increase sitting stability.
    - To discourage hip dislocation.
  - **Considerations**
    - Medial knee support should never be used to hold a student in the wheelchair.
    - Medial knee support should be removable to allow for transfers and personal care.
• Medial knee support should be firm to provide for alignment.
• Overall medial knee support width and length must be evaluated on an individual basis.

• **Lateral Knee Support:**
  o Reasons
    - To maintain the lower extremity in neutral alignment.
  o Considerations
    - An individual may typically need bilateral knee supports.
    - It is important to avoid pressure over the fibula head, and do not force medially if passive movement is not present.

• **Footrests and Straps:**
  o Reasons
    - To provide a stable base of support on which to build trunk, upper extremity, and head control.
    - To inhibit the influence of abnormal tone, thereby maintaining proper pelvic position.
    - To discourage circulatory problems.
  o Considerations
    - Foot position follows the angle of the knee.
    - Weight bearing should be through a flat foot and equal on the heel and sole; in the case of foot orthoses, angle-adjustable foot plates might be needed.
    - The purpose of heel loops, foot straps, etc., is to maintain the feet in forward alignment.
    - Accommodations may be necessary for lower leg discrepancy.

E. **Upper Extremities**

Evaluate the tone in the upper extremities in regard to type and predominant movements. Also, evaluate the range of motion and patterns of movement that interfere with positioning. Consider the following:

• **Upper Extremity Support Surface:**
  o Reasons
    - Encourages upper trunk extension and upright sitting through weight bearing on the forearms.
    - Provides for a functional work surface.
  o Considerations
    - Height of support surface should support the flexed elbow and forearm.
    - Determine material used in support surface in view of functional vision.
    - Size of support surface should not be wider than the widest part of the wheelchair, and the depth should end at the student’s toes.

• **Elbow Blocks:**
  o Reasons
    - Prevents arms from falling off the tray/arm rest when the wheelchair is tilted or when the child has excessive posterior arm movement.
Considerations

- It is important to take into account the student’s size when determining the size of elbow blocks.
- Elbow blocks can be mounted to wheelchair or to upper extremity support surfaces.

- **Type of Arm Rest:**
  - **Reasons**
    - Encourages upper trunk extension through weight on the forearms.
  - **Considerations**
    - Adjustable height can grow with the student.
    - Desk length allows the student to move in closer to his work area.

**IV. Functional Skill Level**

Using the following letters, describe the student’s physical/functional ability.

- I = Independent
- A = Assisted independent
- D = Dependent

Describe the student’s gross and fine motor ability. Consider the following:

- **Frame, Wheels, Wheel Rim, and Casters:**
  - **Reasons**
    - Can accommodate for growth changes.
    - Affects overall weight of the wheelchair and thus affects the maneuverability of the wheelchair.
  - **Considerations**
    - Lifestyles of the family.
    - Surfaces where the wheelchair will be used.
    - Need for pneumatic wheels and casters, solid inserts, etc.
    - How the wheelchair will be transported.

- **Anti-tippers:**
  - **Reasons**
    - Prevents the wheelchair from tipping over posteriorly and causing serious injury to the student.

- **Transit Option:**
  - **Reasons**
    - To provide for safe transportation to and from medical appointments and school.
    - To prevent the wheelchair from tipping over during transportation, causing serious injury to the child.
    - To minimize the need for repairs to wheelchair due to incorrect tie down attachment and subsequent damage to wheelchair.
• **Extension Handles:**
  o Reasons
    ▪ To allow for movement of student while in a maximum posteriorly tilted position.
    ▪ To maintain the child consistently in the tilted position for medical reasons.

V. **Powered Wheelchair Operation Assessment**

The best way to assess a student’s potential in regard to powered mobility is to have the student try a powered wheelchair. Also, assess ability through joystick control and computer programs, if appropriate.

VI. **Seating Measurements**

Be sure to measure each side individually. (Measurements are not applicable if modifications are not needed [e.g., if the student has good head control, head and neck measurements are not needed].)

VII. **Recommendations**

Describe the frames that were considered, and give the approximate cost.

Circle or indicate the appropriate description/measurement of the wheelchair frame and positioning adaptations needed by the student. Be sure to complete each line.

NOTE: The “Signature Page” is provided when the wheelchair evaluation is being submitted to Medicaid or other third party payer for payment.
Wheelchair Assessment

Assessment Date: _____________________

I. Identifying Information

Name _________________________________    M☐ F ☐

DOB ________________________________    Age _______

Primary Diagnosis __________________________    Date of Onset _______

Secondary Diagnosis __________________________

Medicaid # ________    Insurance Company: ______________________

Children’s Medical Services client: ☐ Yes ☐ No
Agency for Persons with Disabilities client: ☐ Yes ☐ No

Parent/Guardian __________________________________________________________

Street Address __________________________________________________________

City ____________________________ State ______________ Zip ____________

Home Phone ________________    Work Phone ______________________

Referring Physician ______________________________________________________

Occupational Therapist Evaluator ______________________    Phone#: __________

Physical Therapist Evaluator ______________________    Phone#: __________

Name of School ______________________________

Days per Week__________________________    Hours __________

Therapies: Specify (OT, PT)

Type __ Site ____________ Minutes/wk ____________

Type __ Site ____________ Minutes/wk ____________

Summary of Needs for Custom Wheelchair ____________________________________

________________________________________________________________________

________________________________________________________________________

Past Surgeries (if applicable) ______________________________________________

________________________________________________________________________
II. Wheelchair Use

At Home: □ Yes □ No    At School: □ Yes □ No
Number of hours per day child is in wheelchair: __________________________
Is the home accessible? □ Yes □ No
Are modifications needed: (If yes, explain) ________________________________

Means of transporting the wheelchair: _________________________________
Does the child ride a school bus? □ Yes □ No
Describe the current wheelchair frame: ________________________________
Can the frame be renovated or resized for further use?
  □ Yes, describe what needs to be done: ________________________________
  □ No, describe why not: ________________________________

Where was the current wheelchair obtained?
  Vendor: ___________________________  Date: __________________
Describe the current seating system: ________________________________
Can any components of the current seating system be used?
  □ Yes, list the components: ________________________________
  □ No, describe why not: ________________________________

III. Musculoskeletal Status

A. Pelvis/Hip

Pelvic Tilt:
  Neutral Tilt __________________________
  Anterior Pelvic Tilt ________________
  Posterior Pelvic Tilt ________________

Pelvic Obliquity:
  Present ________  Not Present _________
  Which side is higher?
  Left ________  Right ________________
  Which side is forward?
  Left ________  Right ________________

Thigh Length:
  Left __________  Right ________________
  Measurement is taken from just behind the hips to the popliteal fossa. For seat
depth then subtract 0.5” to 1.0”.
Windswept Lower Extremities:

None
Toward Left
Toward Right

Hip Dislocation

None
Left
Right

*Be sure all custom modifications are medically justified.

### Custom Modifications and Medical Necessity:

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>Solid Seat:</td>
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<tr>
<td>Hip Positioners:</td>
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<td>Split Length Seat:</td>
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<td>Positioning Belt:</td>
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<td>Other:</td>
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</table>

B. Skin:

Does the student/child have sensory impairment in his/her lower extremities?

☐ Yes  Location ________________

☐ No

Has the student/child had skin breakdown?

☐ Yes  Location ________________

☐ No

What is currently being used for pressure relief? __________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________

__________________________________________________________________________________________________________
Custom Modifications and Medical Necessity:

Specialized Cushion: __________________________________________
________________________________________________________________
________________________________________________________________

C. Trunk/Head:

Spinal Deformities:

None: __________________________
Kyphosis: ______________ Fixed: _____ Correctable: ______
Lordosis: ______________ Fixed: _____ Correctable: ______
Scoliosis: ______________ Fixed: _____ Correctable: ______
C-Curve ______________ Location _____________________________
S-Curve ______________ Location _____________________________

Describe posture/tone in sitting:

________________________________________________________________

Does posture change when tired?
☐ Yes  ☐ No

If yes, describe what occurs: ______________________________________

________________________________________________________________

Head control in supported sitting?

Is the head erect?
80–100% of the time ☐
50–79% of the time ☐
0–49% of the time ☐

When the head is not erect it is?
Tilted to the left ☐
Tilted to the right ☐
Dropped forward ☐
Hyperextended at the neck ☐
**Custom Modifications and Medical Necessity:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
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<tbody>
<tr>
<td>Solid Back</td>
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<tr>
<td>Lateral Trunk Supports</td>
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<tr>
<td>Tilt in Space System</td>
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<tr>
<td>Harness System and Strap Guides</td>
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<tr>
<td>Head Control System</td>
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<td>Other</td>
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**D. Lower Extremities:**

**Tone:**

Left: ____________________________
Right: _________________________

**Range of Motion:**

List presence of limited ranges or contractures that interfere with positioning:

<table>
<thead>
<tr>
<th>Joint</th>
<th>Left:</th>
<th>Right:</th>
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<tbody>
<tr>
<td>Hip</td>
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<tr>
<td>Knee</td>
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<tr>
<td>Ankle</td>
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</table>
Lower Leg Length:

Left _____ Right _____
(Measurement is taken from popliteal fossa to the heel.)

Patterns limiting movement/positioning:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Custom Modifications and Medical Necessity:

Medial Knee Support: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Lateral Knee Support: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Footrests and Straps: __________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Accommodations for the lower leg length discrepancy: ____________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Other: ______________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

E. Upper Extremities:

Tone:

Left: ______________________________________________________________________
Right: ______________________________________________________________________

Range of Motion:

List presence of limited ranges or contractures that interfere with positioning:
Shoulder:  Left: __________________________________________________________________
Right: ______________________________________________________________________
Elbow:    Left: __________________________________________________________________
Right: ______________________________________________________________________
Wrist: Left: ____________________________________________
Right: ____________________________________________

Describe patterns limiting movement/positioning:
____________________________________________________________________________________
____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Custom Modifications and Medical Necessity:</th>
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<tbody>
<tr>
<td>Upper Extremity Support Surface:</td>
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<td>Elbow Blocks:</td>
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<tr>
<td>Type of Arm Rest:</td>
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<td>Other:</td>
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IV. Functional Skill Level:

Codes:
I = Independent   D = Dependent   A = Assisted

Sitting: Floor ______ Bench ________

Transfers:__________ Describe:________________________________________

Self Care: Feeding ________ Dressing_______ Hygiene__________

Toileting:___________

Is the student ambulatory: ☐ Yes ☐ No

If yes, check all the conditions/areas in which the student is ambulatory:
Exercise: ________________ Household: ________ Community:_________
Assistive Device:  □ Yes  □ No  
If “yes” describe: ____________________________________________
____________________________________________________________________________

Wheelchair Control:
Dependent ________  Independent ____________
Self-propel manually ____________
Self-propel power ____________
Distances: Long ____________  Short ____________

Developmental Status:
Describe gross motor ability: __________________________________________
____________________________________________________________________________

Describe fine motor ability: __________________________________________
____________________________________________________________________________

**Custom Modifications and Medical Necessity:**

Type of Frame: __________________________________________
____________________________________________________________________________

Type of Wheel Rims: _________________________________________
____________________________________________________________________________

Type of Wheels: ____________________________________________
____________________________________________________________________________

Type of Casters: ____________________________________________
____________________________________________________________________________

Anti-Tippers: _______________________________________________
____________________________________________________________________________

Transit Option: _____________________________________________
____________________________________________________________________________

Extension Handles: __________________________________________
____________________________________________________________________________

Other: ______________________________________________________
____________________________________________________________________________
V. Powered Wheelchair Operation Assessment:

- Has severe abnormal upper extremity dysfunction/weakness: ___  ___
- Propels lightweight manual chair: ___  ___
- Has sufficient cognitive/perceptual skills: ___  ___
- Has sufficient eye skills: ___  ___
- Able to operate/control wheelchair during trials: ___  ___
- Has wheelchair accessible transportation: ___  ___
- Facilitates social/recreational skills with wheelchair: ___  ___
- Facilitates learning/educational opportunities with wheelchair: ___  ___

Control switch recommendation: ___________________________________________________

To be controlled by: _____________________________________________________________

Briefly describe how the student was able to maneuver the wheelchair during trials: __________________

Seating Measurements: (Child must be wearing braces, shoes, body jacket, etc., during all measurements).

<table>
<thead>
<tr>
<th>Left:</th>
<th>Right:</th>
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</thead>
<tbody>
<tr>
<td>Behind hips to politeal fossa</td>
<td></td>
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<tr>
<td>Popliteal fossa to heel</td>
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<tr>
<td>Knee flexion angle</td>
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<tr>
<td>Sitting surface to axilla</td>
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<td>Sitting surface to shoulder</td>
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<tr>
<td>Sitting surface to top of lateral support</td>
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<tr>
<td>Sitting surface to hanging elbow</td>
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<tr>
<td>Depth of trunk</td>
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<td>Heel to toe</td>
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</table>

Other:

- Sitting surface to occiput
- Sitting surface to crown of head
- Width across shoulders
- Width across trunk
- Width across hips
- Width across the thighs
- Seat belt girth
- Head circumference
- Neck circumference
- Height
- Weight
VII: Recommendations:

A. The following wheelchair frames were considered due to their durability, safety, transportability, and their ability to be changed to accommodate physical growth.

<table>
<thead>
<tr>
<th>Basic Frame</th>
<th>Approximate Cost</th>
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<tbody>
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<td>2.</td>
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</table>

B. The most appropriate wheelchair for this child/student is summarized as follows (circle the appropriate responses and/or fill in the blank spaces when necessary):

Frame:
- Style: Reg, Hemi, Kids, Adult, Tall, One Arm Drive, Tilt in Space, Folding, Rigid
- Arm Rests: Desk, Full-length, Fixed, Height adjustable, Tube, Omit
- Footrest Hangers: 90, 70, 60, Elevating, Smart Leg, Removable, Fixed, Omit
- Footplates: Standard, Angle adjustable, Fixed, Other
- Rear Wheels: Pneumatic, Solid, 12, 20, 22, 24, 26, Spoke, Mag
- Front Casters: Pneumatic, Solid 3, 5, 6, 8, 10, 12
- Brakes: Push, Pull, High Mount, Low Mount
- Brake Extensions: L, R, Both
- Back Height: 8, 10, 12, 14, 16, 18, 20, 22, 24, Other:
- Seat Width: 8, 10, 12, 14, 16, 18, 20, 22, 24, Other:
- Seat Depth: 8, 10, 12, 14, 16, 18, 20, 22, 24, Other:
- Tilt in Space: Manual, Power, Omit
- Recline: Manual, Power, Omit
- Anti Tippers: ☐ Yes ☐ No
- Transit Option: ☐ Yes ☐ No
- Extension Handles: ☐ Yes ☐ No
- Power Chair: ☐ Yes ☐ No Type of battery: Acid, Gel
- Joystick Mount: Right, Left, Center, Other: N/A Swing away, Fixed
- Joystick Handle: Ball, T-Style, Straight Stick, N/A, Other
- Programmable by: User, Dealer, Both, N/A
- Computer/AAC Mount: Describe: _____________________________________________

___________________________________________
___________________________________________
___________________________________________
C. Custom Modifications:

Solid Seat: Removable, Fixed, Split Length Right Left
Hardware: Fixed, Adjustable
Foam Type: Thickness: \( \frac{1}{2} \)”, 1”, 2”
Other:
Cover: Vinyl, Para, Color:
Solid Back: Removable, Fixed, I Back, T Back
Hardware: Fixed, Adjustable
Foam Type: Thickness \( \frac{1}{2} \)”, 1”, 2” Other:
Cover: Vinyl, Para, Color:

Special Cushion: Describe:___________________________________________

Special Back: Describe:___________________________________________

Positioning Belt: Buckle, Airplane, Velcro, Plastic, Metal
Width: 1”, 1\( \frac{1}{2} \)””, 2”

Padded Nonpadded Other _____________

Lateral Thigh Supports: Fixed, Swing away
Pad Size: _____________
Lateral Trunk Supports: Fixed Removable Swing away
Pad Size: _____________
Straight Curved
Hip Positioners: Fixed, Swing away Pad Size: _____________
Medial Thigh Supports: Fixed, Removable, Flip Down, Pad Size: _____________
Anterior Knee Block: Yes No
Subasis Bar: Yes No
Ankle Straps: Velcro Buckle, D-ring, Leather
Size: ______ Width: ______ Length Each Side: _____________
Heel Loops: ABS, Fabric, Shoe Holder, Other:
Toe Loops: Velcro, Buckle, D Ring, Leather, NA
Size: ______ Width: ______ Length Each Side: _____________
Headrest: Fixed, Removable, Flip Down
Describe:___________________________________________

Upper Extremity
Support Surface: Lexan, Wood, Other: ______ Omit
Mounting Hardware: Cams, Toggle, Slide On
Elbow Blocks: On Tray, On Chair Pad Size: ______ Omit
Harness System: H-Style, X-Style, Chest Belt, Padded, Soft, Hard Rubber
Strap Guides: Yes No
Arm Rest Pads: Standard, Troughs, Flat Pad Size
Shoulder Retractors: Length: ______ Pad Size: ______
Signature Page

This is to certify that the following people have been consulted and/or participated in this evaluation for an adaptive seating and mobility system for ________________________________.

Student’s Name

Conflict of Interest

This also certifies that no consultant or participant in this evaluation process has any fiduciary interest or association with manufacturers, vendors, or dealers of the above prescribed equipment.

Signatures

Occupational Therapist Signature: ____________________________ Date: __________
Name Printed or Typed: ____________________________
Medicaid Provider Number: ____________________________

Physical Therapist Signature: ____________________________ Date: __________
Name Printed or Typed: ____________________________
Medicaid Provider Number: ____________________________

Physician Signature: ____________________________ Date: __________
Name Printed or Typed: ____________________________
Physician Medical Provider Number: ____________________________
Physician DEA Number: ____________________________

Parent/Legal Guardian Signature: ____________________________ Date: __________
Name Printed or Typed: ____________________________

DME Signature

DME Provider Signature: ____________________________ Date: __________
Name Printed or Typed: ____________________________
Medicaid Provider Number: ____________________________