UIC UNIVERSITY OF ILLINOIS AT CHICAGO

POWER MOBILITY EVALUATION REPORT

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Date:_____

*** Please attach completed *Power Mobility Skills Checklist* (05.34) to this questionnaire.**

SECTION I—PATIENT INFORMATION

Name:_____ Birth Date:_____

Address:_____ City:_____ State:_____

What type of environment does the child reside in (e.g.: single story home, an apartment complex); how will the power chair access this environment? Please give full detail:

_____

_____

SECTION II—MEDICAL HISTORY

Height:_____ Weight:_____

Date or onset of condition/injury requiring use of mobility device:_____

Diagnosis(es) *(please include written description and ICD-9 Codes):*_____

_____

How has the child's condition progressed to now requiring power mobility?_____

_____

Child's current ambulatory status *(please include any assistive device, physical assistance and degree of assistance required)*:_____

Child's current ability to perform activities of daily living (ADL) in home and other environments; how will this chair improve the child's ability to perform ADL independently *(please include any assistive device, physical assistance and degree of assistance required)*:_____

_____

Does the child currently have a mobility device?

☐ Yes ☐ No

If yes, list: Make:_____ Model:_____ Age of Equipment:_____

Functional status (please provide quantitative measurements):

ROM limitations:_____

Muscle strength limitations:_____

Upper extremity function:_____

SECTION II—MEDICAL HISTORY (Cont'd)

Lower extremity function: _____

Ability to transfer: _____

Endurance: _____

Communication *(is an augmentative communication device used)*? _____

SECTION III—PHYSICAL ASSESSMENT

Sitting posture/balance: _____

Pelvic tilt/obliquity/rotation: _____

Leg position: _____

Scoliosis: _____

Lordosis/kyphosis: _____

Head position: _____

Shoulder/scapula position: _____

Movement/strength: _____

Tone/spasms: _____

Skeletal/physical limitations/deformities/abnormalities: _____

Respiratory status: _____

Skin Condition/Integrity

Susceptible to decubitus ulcers? ☐ Yes ☐ No
If yes, explain: _____

Sensation: _____

Present/history of ulcers: _____

Location(s): _____

Stage: _____

Ability to perform pressure relief: _____

Bowel/bladder status (toileting): _____

SECTION IV—ADDITIONAL QUESTIONS FOR MEDICAL NECESSITY *

Has the child been evaluated using the power wheelchair in the home?_____

Have any barriers been identified for use of a power wheelchair in the home *(e.g.; front door entrance, hallways, van)*?

☐ Yes ☐ No

If yes, please describe barrier(s) and how it/they will be addressed:_____

_____

Where will the child primarily use the equipment?_____

_____

How will the power wheelchair be transported to and from medical visits?_____

_____

Rationale and benefits of power mobility for this child:_____

_____

What other mobility devices were considered? Please list type and reason why a less expensive device is not sufficient to meet child's needs:_____

_____

Recommendations:

Mobility base – specify make/model:_____

Option – specify each option/accessory and why the item is required for this child:_____

_____

_____

_____

Seating–specify special seating components, including supports and why the item is required for this child:

_____

_____

_____

Vendor Information:

Equipment Supplier:_____

Address:_____ City:_____ State:_____

Phone Number:_____

SIGNATURE(S)

I have reviewed Sections I, II, III and IV of this clinical assessment and agree that it is an accurate assessment of the client and their needs.

Therapist's Name:_____
(Please print) *Phone #:* *Fax #*

Therapist's Signature:_____ Date:_____
(Signature)

Physician's Name:_____
(Please print) *Phone #:* *Fax #*

Physician's Signature:_____ Date:_____
(Signature)

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Clear Form