

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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