|  |  |  |  |
| --- | --- | --- | --- |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Member Information and Background** | | | | | | | |
| **\*1.** | Date of Birth (mm/dd/yyyy) | |  | | | | |
| **2.** | Date(s) of Evaluation (mm/dd/yyyy) | |  | | | | |
| **\*3.** | Address Line 1 | |  | | | | |
| Address Line 2 | |  | | | | |
| City |  | | State |  | Zip Code |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **\*4.** | Facility Name, if applicable Evaluation Location Address L1 | |  | | | | |
| Evaluation Location Address L 2 | |  | | | | |
| Evaluation City |  | | Evaluation State |  | Evaluation Zip Code |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*5.** | Height |  | FT |  | IN | Weight |  | **LBS** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **\*6.** | **INDIVIDUALS PRESENT DURING EVALUATION** | | | |
|  | | **NAME** | **CREDENTIALS** | **AGENCY or RELATIONSHIP** |
| **OCCUPATIONAL/PHYSICAL THERAPIST(s)** | |  |  |  |
|  | |  |  |  |
| **DME PROVIDER/ATP** | |  |  |  |
| **PHYSICIAN(s), if present** | |  |  |  |
| **OTHER(s)** | |  |  |  |
|  | |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **7.** | a. Primary  Reason for  Evaluation |  | Initial Wheeled Mobility Device | **b. Primary Issues Relating to DME** |  | Size | |
|  | Replacement |  | Does not address current medical needs | |
|  | Modification/Repairs |  | Does not address current functional needs | |
|  | | | | | | | |
|  | **DIAGNOSIS(es), RECENT SURGERIES and PROCEDURES** | | | | | | **RELEVANT DATE(s)/DATES of ONSET or INDICATE N/A** |
| **8.** |  | | | | | |  |
|  | | | | | |  |
|  | | | | | |  |
|  | | | | | |  |
| **8a.** | **Explain recent change in medical condition or other relevant information including symptoms, treatments and medications:** | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

**9. Caretaker Support**:  **The individual has 24 Hour Care.**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **9a.** | Caretaker Support Hours per Day |  | 1 – 3 Hours |  | 3 – 10 Hours |  | > 10 Hours |  | N/A |
| Relationship/Role: | | | | | | | | | |
| **9b.** | Amount of Time Alone per Day |  | 1 – 3 Hours |  | 3 – 10 Hours |  | > 10 Hours |  | N/A |

10. List all current/previous Durable Medical Equipment (DME) within past 10 years:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **10a. WHEELED MOBILITY DEVICE including MANUFACTURER  AND MODEL** | | | **Approximate DATE of PURCHASE** | | | **ENVIRONMENTS USED Indicate All That Apply** | | | | **Is DME currently used?** | | **Skill Level** | | | **If ineffective, provide reason** |
| e.g. Convaid Cruiser stroller | | |  | | |  | Home | | |  | Yes |  | Independent | |  |
|  | | | | | |  | Work | | |  | No |  | WNL endurance/distance | |
|  | School | | |  | N/A |  | Below normal endurance/distance | |
|  | Community | | |  | |  | Dependent | |
|  | SNF/ICF | | |  | Other: | |
| Comments, including special features, specialty seating components, electronics: | | | | | | | | | | | | | | | |
| Ownership |  | Personally Owned | |  | Facility Owned | | |  | Rental, include dates: | | | | |  | Other: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **10b. WHEELED MOBILITY DEVICE including MANUFACTURER  AND MODEL** | | | **Approximate DATE of PURCHASE** | | | **ENVIRONMENTS USED Indicate All That Apply** | | | | **Is DME currently used?** | | **Skill Level** | | | **If ineffective, provide reason** |
| e.g. Convaid Cruiser stroller | | |  | | |  | Home | | |  | Yes |  | Independent | |  |
|  | | | | | |  | Work | | |  | No |  | WNL endurance/distance | |
|  | School | | |  | N/A |  | Below normal endurance/distance | |
|  | Community | | |  | |  | Dependent | |
|  | SNF/ICF | | |  | Other: | |
| Comments, including special features, specialty seating components, electronics: | | | | | | | | | | | | | | | |
| Ownership |  | Personally Owned | |  | Facility Owned | | |  | Rental, include dates: | | | | |  | Other: |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **10c.**  **OTHER DME TYPE**  **including MANUFACTURER  AND MODEL** | **Approximate DATE of PURCHASE** | **ENVIRONMENTS USED**  **Indicate All That Apply** | **Skill Level using DME** | **Is DME currently used?** | **If ineffective, provide reason** |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hygiene** |  |  | Home |  | SNF/ICF |  | Independent |  | Yes |  |
| e.g. Anthros Shower/Commode Chair | |  | School |  | Community |  | Requires Assistance |  | No |
|  | Work |  | Other: |  | Dependent |  | N/A |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Stander** |  |  | Home |  | SNF/ICF |  | Independent |  | Yes |  |
| e.g. Altimate EasyStand Evolv | |  | School |  | Community |  | Requires Assistance |  | No |
|  | Work |  | Other: |  | Dependent |  | N/A |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Other Equipment** |  |  | Home |  | SNF/ICF |  | Independent |  | Yes |  |
| e.g. Hospital Bed, Patient Lift, Walker | |  | School |  | Community |  | Requires Assistance |  | No |
|  | Work |  | Other: |  | Dependent |  | N/A |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Other Equipment** |  |  | Home |  | SNF/ICF |  | Independent |  | Yes |  |
|  | |  | School |  | Community |  | Requires Assistance |  | No |
|  | Work |  | Other: |  | Dependent |  | N/A |

|  |  |  |  |
| --- | --- | --- | --- |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

11. Functional Skills

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ACTIVITY** | **LEVEL OF INDEPENDENCE** | | | | | | **COMMMENTS and EQUIPMENT USED** |
| **Bathing** |  | Independent |  | Min Assistance |  | Max Assistance |  |
|  | Supervision |  | Mod Assistance |  | Dependent |
| **Dressing** |  | Independent |  | Min Assistance |  | Max Assistance |  |
|  | Supervision |  | Mod Assistance |  | Dependent |
| **Grooming** |  | Independent |  | Min Assistance |  | Max Assistance |  |
|  | Supervision |  | Mod Assistance |  | Dependent |
| **Eating** |  | Independent |  | Min Assistance |  | Max Assistance |  |
|  | Supervision |  | Mod Assistance |  | Dependent |
| **Toileting** |  | Independent |  | Min Assistance |  | Max Assistance |  |
|  | Supervision |  | Mod Assistance |  | Dependent |

12. Orthosis(es)/Prosthesis(es)  NA / None

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ITEM** | **LEFT** | **RIGHT** | **BOTH** | **COMMENTS/ IF INEFFECTIVE, PLEASE EXPLAIN** |
| **Ankle Foot Orthosis(es)** |  |  |  |  |
|
|
| **Knee-Ankle-Foot Orthosis(es)** |  |  |  |  |
|
|
| **Below Knee Prosthesis(es)** |  |  |  |  |
| **Above Knee Prosthesis(es)** |  |  |  |  |
|
|
| **TLSO/ LSO** | N/A | | |  |
| **Other:** |  |  |  |  |
|
|

13. Transfer Skills  Independent for all transfers  Varied transfer skills; see completed table

Dependent for all transfers; describe transfer method and equipment used

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FROM** | | | **TO** | | **METHOD** | | **LEVEL OF INDEPENDENCE** | | | | **EQUIPMENT** | |
|  | Bed | |  | Bed |  | Stand pivot |  | | Independent | |  | None |
|  | Wheeled Mobility Device | |  | Wheeled Mobility Device |  | 1 Person Lift |  | | Supervision | |  | Mechanical Lift |
|  | Chair | |  | Chair |  | 2 Person Lift |  | | Min Assistance | |  | Ambulation Aide |
|  | Hygiene Equipment | |  | Hygiene Equipment |  | Other: |  | | Mod Assistance | |  | Sliding Board |
|  | Other: | |  | Other: |  | | Max Assistance | |  | Other: |
|  | | Dependent | |
|  | Bed | |  | Bed |  | Stand pivot |  | | Independent | |  | None |
|  | Wheeled Mobility Device | |  | Wheeled Mobility Device |  | 1 Person Lift |  | | Supervision | |  | Mechanical Lift |
|  | Chair | |  | Chair |  | 2 Person Lift |  | | Min Assistance | |  | Ambulation Aide |
|  | Hygiene Equipment | |  | Hygiene Equipment |  | Other: |  | | Mod Assistance | |  | Sliding Board |
|  | Other: | |  | Other: |  | | Max Assistance | |  | Other: |
|  | | Dependent | |
|  | Bed | |  | Bed |  | Stand pivot |  | | Independent | |  | None |
|  | Wheeled Mobility Device | |  | Wheeled Mobility Device |  | 1 Person Lift |  | | Supervision | |  | Mechanical Lift |
|  | Chair | |  | Chair |  | 2 Person Lift |  | | Min Assistance | |  | Ambulation Aide |
|  | Hygiene Equipment | |  | Hygiene Equipment |  | Other: |  | | Mod Assistance | |  | Sliding Board |
|  | Other: | |  | Other: |  | | Max Assistance | |  | Other: |
|  | | Dependent | |
| **\***INDIVIDUAL’S NAME: | |  | | | | | | \* ID NUMBER: | |  | | |

14. Ambulation Independence:  Independent  Requires assistance with ambulation  Non-ambulatory  Varied ambulation skills; see completed table

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **LEVEL OF ASSISTANCE** | | **SPEED** | | **DISTANCE** | | **ENDURANCE** | | **SPECIFY AMBULATION AIDE** | |
| **Carpet** |  | Independent |  | WNL |  | < 10 ft |  | < 5 min |  | None |
|  | Assistance with Ambulation |  | Slow |  | 10 – 30 ft |  | 5 – 10 min |  | |
|  | Non-Ambulatory |  | |  | 30 – 100 ft |  | 10 – 30 min |
|  | | | |  | > 100 ft |  | > 30 min |
|  | Other: |  | Other: |
| **Smooth** |  | Independent |  | WNL |  | < 10 ft |  | < 5 min |  | None |
|  | Assistance with Ambulation |  | Slow |  | 10 – 30 ft |  | 5 – 10 min |  | |
|  | Non-Ambulatory |  | |  | 30 – 100 ft |  | 10 – 30 min |
|  | | | |  | > 100 ft |  | > 30 min |
|  | Other: |  | Other: |
| **Uneven Terrain (outside)** |  | Independent |  | WNL |  | < 10 ft |  | < 5 min |  | None |
|  | Assistance with Ambulation |  | Slow |  | 10 – 30 ft |  | 5 – 10 min |  | |
|  | Non-Ambulatory |  | |  | 30 – 100 ft |  | 10 – 30 min |
|  | | | |  | > 100 ft |  | > 30 min |
|  | Other: |  | Other: |

15. Coordination, Motor Control, and Balance

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ACTIVITY** | **UNSUPPORTED MOTOR CONTROL** | | | | | | **COMMENTS / OTHER** |
| **Sitting Balance (Static)** |  | Steady, safe |  | Leans or slides |  | Unable |  |
| **Upper Extremity  Gross Motor Control** |  | Functional |  | Mild/Moderate  Impairment |  | Dependent |  |
| **Upper Extremity Fine Motor Control** |  | Functional |  | Mild/Moderate  Impairment |  | Dependent |  |

16. Range of Motion (Attach data as appropriate)

|  |  |
| --- | --- |
| **AREA AFFECTED** | **RANGE OF MOTION LIMITATIONS RELATIVE TO SEATING** |
| **Right Upper Extremity** |  |
| **Left Upper Extremity** |  |
| **Right Lower Extremity** |  |
| **Left Lower Extremity** |  |
| **Head/Neck** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| \*INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

##### 17. Motor Control, Muscle Strength, and Tone

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STRENGTH** | | | **( + ) / ( - )** |  | | **( + ) / ( - )** | **TONE** | | | | **COMMENTS / OTHER** |
| **Head/Neck** |  | WNL (5) | (     ) |  | Poor (2) | (     ) |  | WNL |  | Spasticity |  |
|  | Good (4) | (     ) |  | Trace (1) | (     ) |  | Hypotonia/Flaccid |  | Rigidity |
|  | Fair (3) | (     ) |  | Absent (0) | (     ) |  | Dystonia |  | Mixed Tone |
| **Trunk** |  | WNL (5) | (     ) |  | Poor (2) | (     ) |  | WNL |  | Spasticity |  |
|  | Good (4) | (     ) |  | Trace (1) | (     ) |  | Hypotonia/Flaccid |  | Rigidity |
|  | Fair (3) | (     ) |  | Absent (0) | (     ) |  | Dystonia |  | Mixed Tone |
| **Right Upper Extremity** |  | WNL (5) | (     ) |  | Poor (2) | (     ) |  | WNL |  | Spasticity |  |
|  | Good (4) | (     ) |  | Trace (1) | (     ) |  | Hypotonia/Flaccid |  | Rigidity |
|  | Fair (3) | (     ) |  | Absent (0) | (     ) |  | Dystonia |  | Mixed Tone |
| **Left Upper Extremity** |  | WNL (5) | (     ) |  | Poor (2) | (     ) |  | WNL |  | Spasticity |  |
|  | Good (4) | (     ) |  | Trace (1) | (     ) |  | Hypotonia/Flaccid |  | Rigidity |
|  | Fair (3) | (     ) |  | Absent (0) | (     ) |  | Dystonia |  | Mixed Tone |
| **Right Lower Extremity** |  | WNL (5) | (     ) |  | Poor (2) | (     ) |  | WNL |  | Spasticity |  |
|  | Good (4) | (     ) |  | Trace (1) | (     ) |  | Hypotonia/Flaccid |  | Rigidity |
|  | Fair (3) | (     ) |  | Absent (0) | (     ) |  | Dystonia |  | Mixed Tone |
| **Left Lower Extremity** |  | WNL (5) | (     ) |  | Poor (2) | (     ) |  | WNL |  | Spasticity |  |
|  | Good (4) | (     ) |  | Trace (1) | (     ) |  | Hypotonia/Flaccid |  | Rigidity |
|  | Fair (3) | (     ) |  | Absent (0) | (     ) |  | Dystonia |  | Mixed Tone |

**18. Unsupported Postural Alignment: Add COMMENT regarding any abnormal finding, including quantitative data; e.g., mixed asymmetry, mixed rotation, severe misalignment between neck and trunk.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **POSTURAL ALIGNMENT** | | | | **FIXED VS. FLEXIBLE** | | **COMMENTS** |
| **Head/**  **Neck** |  | WNL |  | Forward |  | Flexible |  |
|  | Tilted |  | Extended |  | Limited |
|  | Rotated |  | Mixed/Other |  | Fixed |
| **Trunk/**  **Spine** |  | WNL |  | Lordosis |  | Flexible |  |
|  | Scoliosis |  | Rotation |  | Limited |
|  | Kyphosis |  | Mixed/Other |  | Fixed |
| **Pelvis/**  **Hips** |  | Even |  | Left Posterior Rotation |  | Flexible |  |
|  | Posterior Pelvic Tilt |  | Pelvic Obliquity, Lower on Right |  | Limited |
|  | Anterior Pelvic Tilt |  | Pelvic Obliquity, Lower on Left |  | Fixed |
|  | Right Posterior Rotation |  | Mixed/Other |  | |
| **Leg Length** |  | Even |  | Discrepancy |  | |  |
|  | Other | | |
| **Ankles/  Feet/**  **Toes** |  | Neutral |  | Pes Cavus |  | Flexible |  |
|  | Tibial Torsion |  | Hyperpronation |  | Limited |
|  | Varus Heels |  | Hallux Valgus |  | Fixed |
|  | Valgus Heels |  | Plantar-Flexed First Ray |  | |
|  | Pes Planus |  | Hammer Toes |
| Other Pertinent Information: | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

19. Pain

No Pain  Unable to determine if individual is experiencing pain

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **LOCATION** | | | | **INTENSITY** | | | | **FREQUENCY** | | **COMMENTS/QUALIFYING INFORMATION;  RELATIONSHIP TO POSITIONING & MOBILITY** |
|  | Neck |  | Lower Back |  | 1 |  | 6 |  | Intermittent |  |
|  | Upper Back |  | Coccyx/Sacrum |  | 2 |  | 7 |  | Daily |  |
|  | Right Upper Extremity |  | Right Lower Extremity |  | 3 |  | 8 |  | Constant |  |
|  | Left Upper Extremity |  | Left Lower Extremity |  | 4 |  | 9 | Other: | |  |
|  | Other: | | |  | 5 |  | 10 |  | |  |
|  | Neck |  | Lower Back |  | 1 |  | 6 |  | Intermittent |  |
|  | Upper Back |  | Coccyx/Sacrum |  | 2 |  | 7 |  | Daily |  |
|  | Right Upper Extremity |  | Right Lower Extremity |  | 3 |  | 8 |  | Constant |  |
|  | Left Upper Extremity |  | Left Lower Extremity |  | 4 |  | 9 | Other: | |  |
|  | Other: | | |  | 5 |  | 10 |  | |  |
|  | Neck |  | Lower Back |  | 1 |  | 6 |  | Intermittent |  |
|  | Upper Back |  | Coccyx/Sacrum |  | 2 |  | 7 |  | Daily |  |
|  | Right Upper Extremity |  | Right Lower Extremity |  | 3 |  | 8 |  | Constant |  |
|  | Left Upper Extremity |  | Left Lower Extremity |  | 4 |  | 9 | Other: | |  |
|  | Other: | | |  | 5 |  | 10 |  | |  |

20. Skin integrity and Pressure Management (Optional: Attach Braden Scale [www.bradenscale.com/images/bradenscale.pdf](http://www.bradenscale.com/images/bradenscale.pdf))

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **RISK FACTORS** |  | None | |  | Bony Prominences | |  | Aged Skin |  | | Fecal and/or Urinary Incontinence |
|  | Circulatory Compromise | |  | Impaired Nutritional Status | |  | Immobility |  | | Sensory Deficits |
| **INDICATE HIGH RISK LOCATIONS** |  | | | | | | | | | | |
| **CURRENT SKIN INTEGRITY STATUS** |  | Intact | Impaired, indicate approximate duration: | | | | | | | | |
| Stage: | | | | Location: | | | If unstageable, describe: | |
| **HISTORY of SKIN INTEGRITY** |  | Intact | Impaired, indicate approximate duration: | | | | | | | | |
| Stage: | | | | Location: | | | If unstageable, describe: | |
| **PRESSURE REDUCING ABILIITES** | | | Functional Self-positioning | | | Impaired Self-positioning | | | | Non Self-positioning | |
| **PRESSURE REDUCING METHODS USED** | |  | | | | | | | | | |

**21. Cardiovascular, Pulmonary, Vascular, Bowel, and Bladder Status**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CONDITION** | | | | | | **CLINICAL OBSERVATIONS / REFERENCE TO DIAGNOSIS** |
| Cardiac Status |  | Normal | | | | |  |
|  | Impaired | | | | |
|  | Unable to Determine Status | | | | |
|  |  | | | | |
| Pulmonary Status |  | Normal | | | | |  |
|  | Impaired | | | | |
|  | Unable to Determine Status | | | | |
|  |  | | | | |
| Vascular Status |  | Normal | | | | |  |
|  | Impaired | | | | |
| If Impaired,  Indicate Edema  Grade Level |  | 1+ Barely detectible impression when finger pressed into skin | | | | |  |
|  | 2+ Slight indentation: 15 seconds to rebound | | | | |
|  | 3+ Deeper indentation: 30 seconds to rebound | | | | |
|  | 4+ >30 seconds to rebound | | | | |
| Bladder Status |  | Continent |  | Incontinent |  | Catheterization | |
| Bowel Status |  | Continent |  | Incontinent |  | Suppository use | |

|  |  |  |  |
| --- | --- | --- | --- |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

22. Summarize the conditions that impact individual’s ability to ambulate and/or transfer safely, independently, and in a timely manner;

e.g., weakness, cardiovascular/respiratory compromise, ROM deficits, imbalance, tone, cognitive deficits, coordination, sensory deficits:

|  |
| --- |
|  |

23. What other least restrictive mobility devices were considered, evaluated, or ruled out?

|  |  |  |
| --- | --- | --- |
|  | | **Reason:** |
|  | Cane |  |
|  | Walker |  |
|  | Standard manual wheelchair |  |
|  | Lightweight wheelchair |  |
|  | Optimally configured ultralightweight wheelchair |  |
|  | Medical stroller |  |
|  | Power assist system |  |
|  | Medical scooter |  |
|  | Other: |  |

24. List the primary medical and functional objectives for the recommended wheeled mobility device, including how this will impact

the individual’s ADL independence:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  | |

PERSON’S ABILITY TO UTILIZE REQUESTED WHEELED MOBILITY DEVICE

25. Will this individual be able to participate in mobilizing the recommended wheeled mobility device?

If YES, complete #25  If NO, proceed to #26

If the individual will be mobilizing the wheeled mobility device, describe the evaluation trials and results including individual’s ability to safely and independently mobilize and utilize the features of the recommended wheeled mobility device system within their customary and relevant environment(s), i.e., bedroom, bathroom, ramp, varied terrain:

|  |
| --- |
| Duration and frequency of evaluation trial(s): |
| Cognitive/ Safety/ Visual-Motor skills: |
| Fine/Gross Motor skills: |
| Strength; Endurance: |
| Ability to control all special features; i.e., power tilt, power recline, power leg rests, seat elevator, power assist, one arm drive, alternative  mobility controls: |

26. Are there anticipated changes in the individual’s customary environments with the next 1-2 years?  NO  YES

If “yes,” how was this taken into consideration for the requested wheeled mobility device?

|  |
| --- |
|  |

27. For residents of Skilled Nursing Facilities:

*If this request is for a replacement wheeled mobility device originally purchased under Sec. 17-134d-46 of the Regulations of Connecticut State Agencies (Customized Wheelchairs in Nursing Facilities), attach a copy of the existing 24-hour positioning plan.*

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| What is the estimated length of time per day that the requested wheeled mobility device will be used? |

28. Upon delivery, will ongoing training be necessary?  NO  If YES, please explain:

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**29. Comments (include e. g., Continued from #xx): Attach additional comments as necessary.**

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| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

**Based on the clinical assessment, the following wheeled mobility device is suggested to address this individual’s medical needs:**

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| **30.** | **\*** Description of DME component: This list can be pre-populated by the DME provider. Postural components can be combined with hardware; e.g., lateral trunk pads with swing-away mounting hardware; phenolic upper extremity support with channel locks and strap. | | **31.** **Medical Rationale to be completed by evaluating therapist only:** **Pre-populated, generic,**  **and general rationales and definitions will not be accepted. Information must include:**   * The rationale for the requested base or component for this specific individual, as correlated with the documented clinical information. * If appropriate, include reason why a standard component would not address the individual’s medical needs. * **Rationales written by the DME provider should be designated with an asterisk** [\*]. Include the reason for hardware and electronic components, as compared to less complex alternatives and correlated with necessary functional or technical outcomes. | | |
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| **32a. I certify that I am the Licensed Occupational and/or Physical Therapist identified below. I have included my credentials, affiliated agency, address, and preferred contact information.  My signature affirms that I solely wrote each section of this report, except where an asterisk [\*] is designated, based upon my own clinical knowledge, training, and evaluation of the individual’s medical condition.** Note: All email correspondences utilize the CHNCT secure email system. | | | | | | | | | | | | |
| Name: | |  | | | Credentials: | |  | | CT License #: | |  | |
| Agency: | |  | | | | | | | | | | |
| Address L1: | |  | | | | | | | | | | |
| Address L2: | |  | | | | | | | | | | |
| City: | |  | | | | State: | |  | Zip Code: | |  | |
| Preferred Phone Number: | |  | | Fax Number: | |  | | Preferred Email Address: |  | | | |
| **ATTENTION: To facilitate a medical necessity determination, please indicate the preferred method for a medical reviewer to contact you, as needed.**  **pHONE  EMAIL  OTHER** | | | | | | | | | | | | |
| **32b. Electronic Signature Agreement.** By clicking “I agree” and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures (“Electronic Signature Policy”)* and (2) your electronic signature below complies with the Electronic Signature Policy.  **If your agency does not comply with this Agreement, a handwritten signature is required.** | | | | | | | | | | | | |
|  | **Therapist’s Signature** | |  | | | | | | | **Date of report (mm/dd/yyyy)** | |  |

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| **\*33. Evaluating Assistive Technology Professional (ATP) signature is required when the ATP provides any technical documentation in #31.** | | | | |
|  | **ATP’s Signature and Credentials** |  | **Date**  **(mm/dd/yyyy)** |  |

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| **34a. Physician’s Contact Information and Signature: By signing below, I have reviewed and concur with the above evaluation:** | | | | | | | | | | | |
| a. | **Prescribing Physician** | |  | | | | b. | **Physician NPI** | |  | |
| c. | **Agency** | |  | | | | d. | **Preferred Phone Number** | |  | |
| e. | **Address** | |  | | | | | | | | |
| **City** | | |  | | **State** |  | | **Zip code** | |  | |
| **Preferred Email** | | |  | | | **Fax** | |  | | | |
| **34b. Electronic Signature Agreement.** By clicking “I agree” and electronically signing below, you certify that: (1) you and the agency/facility in which you are employed agree to follow and are in compliance with the Connecticut Department of Social Services *Conditions for DSS Acceptance of Electronic Signatures (“Electronic Signature Policy”)* and (2) your electronic signature below complies with the Electronic Signature Policy.  **If your agency does not comply with this Agreement, a handwritten signature is required.** | | | | | | | | | | | |
|  | | **Physician’s Signature** | |  | | | | | **Date**  **(mm/dd/yyyy)** | |  |