|  |  |  |  |
| --- | --- | --- | --- |
| **\***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 L2 |       |
|  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** |       |       |       |
| **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 |
|  |
|  | **RELEVANT DIAGNOSIS(es)** |
|  **8.** |        |
| **8a.** | **Explain recent change(s) in medical condition or other relevant information including symptoms, treatments, and medications:**       |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |

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

|  |  |  |
| --- | --- | --- |
| **9a. WHEELED MOBILITY DEVICE, including MANUFACTURER AND MODEL** | **Approximate DATE of PURCHASE** | **If ineffective, provide reason:**  |
| (e.g., Convaid Cruiser stroller) |       |       |
|       |

|  |  |  |
| --- | --- | --- |
| **9b. WHEELED MOBILITY DEVICE, including MANUFACTURER AND MODEL** | **Approximate DATE of PURCHASE** | **If ineffective, provide reason:**  |
| (e.g., Convaid Cruiser stroller) |       |       |
|       |

|  |  |  |
| --- | --- | --- |
| **9c. OTHER DME TYPE, including MANUFACTURER AND MODEL** | **Approximate DATE of PURCHASE** | **If ineffective, provide reason:** |

|  |  |  |
| --- | --- | --- |
| [ ]  **Hygiene** |       |       |
| (e.g., Anthros Shower/Commode Chair)      |
|

|  |  |  |
| --- | --- | --- |
| [ ]  **Stander** |       |       |
| (e.g., Altimate EasyStand Evolv)       |
|

|  |  |  |
| --- | --- | --- |
| [ ]  **Other Equipment** |       |       |
| (e.g., Hospital Bed, Patient Lift, Walker)      |
|

|  |  |  |
| --- | --- | --- |
| [ ]  **Other Equipment** |       |       |
|       |
|

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

 10. 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 |

 11. Transfer Skills: [ ]  Independent for all transfers [ ]  Varied transfer skills (Describe transfer skills and equipment used below.)

 [ ]  Dependent for all transfers (Describe transfer method and equipment used below.)

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

 12. Ambulation Independence: [ ]  Independent [ ]  Requires assistance with ambulation [ ]  Non-ambulatory [ ]  Varied ambulation skills

 (Describe below)

13. 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 |       |

 14. Range of Motion (Attach data as appropriate.)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **RANGE of MOTION** | **STRENGTH** | **TONE** | **COMMENTS** | **PRESENCE of EDEMA (Y/N)** |
| **Head/Neck** |  |  |  |  |  |
| **Trunk** |  |  |  |  |  |
| **Upper Extremity** |  |  |  |  |  |
| **Lower Extremity** |  |  |  |  |  |

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

**15. Postural Alignment: Add COMMENT regarding any abnormal finding, including quantitative data (e.g., mixed asymmetry, mixed rotation, severe misalignment between neck and trunk, presence of orthosis(es)/prosthesis(es), if applicable.**

|  |  |
| --- | --- |
|  | **COMMENTS** |
| **Head/Neck** |       |
|  |  |
|  |  |
| **Trunk/Spine** |       |
|  |  |
|  |  |
| **Pelvis/Hips** |       |
|  |  |
|  |  |
|  |  |
| **Leg Length** |       |
|  |  |
| **Ankles/ Feet/****Toes** |       |
|  |  |
|  |  |
|  |  |
|  |  |

 16. Pain: [ ]  No Pain [ ]  Pain [ ]  Unable to determine if individual is experiencing pain

 (If Pain/Unable to determine pain, describe below.)

 17. Skin Integrity and Pressure Management

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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**  |         |

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

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

|  |  |
| --- | --- |
|  | **Reason:** |
| [ ]  | **Cane** |       |
| [ ]  | **Walker** |       |
| [ ]  | **Standard Manual Wheelchair**  |       |
| [ ]  | **Lightweight Wheelchair**  |       |
| [ ]  | **Optimally Configured, Ultra Lightweight Wheelchair** |       |
| [ ]  | **Medical Stroller** |       |
| [ ]  | **Power Assist System**  |       |
| [ ]  | **Medical Scooter** |       |
| [ ]  | **Other:** |       |

19. List the primary medical and functional objectives for the recommended wheeled mobility device, including how this will impact the individual’s Activities of Daily Living (ADL) independence:

|  |
| --- |
|         |

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

PERSON’S ABILITY TO UTILIZE REQUESTED WHEELED MOBILITY DEVICE

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

 [ ]  If YES, complete #20 [ ]  If NO, proceed to #21

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, alternativemobility controls):       |

 21. Does the individual have caretaker support? [ ]  NO [ ]  YES

 If “YES,” is the caretaker trained and able to participate in mobilizing the recommended wheeled mobility device? If the wheeled mobility device will be used in multiple environments, is the caretaker able and willing to transfer the device to and from the individual’s home, vehicle, and other environments?

|  |
| --- |
|        |

 22. 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.*

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

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

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

|  |  |  |
| --- | --- | --- |
| **23.** | **\*** 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). | **24.** **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.
 |
| a. |       |       |
| b. |       |       |
| c. |       |       |
| d. |       |       |
| e. |       |       |

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

|  |  |  |
| --- | --- | --- |
| f. |       |       |
| g. |       |       |
| h. |       |       |
| i. |       |       |
| j. |       |       |
| k. |       |       |
| l. |       |       |
| m. |       |       |
| **\***INDIVIDUAL’S NAME: |  | **\***ID NUMBER: |  |
| n. |       |       |
| o. |       |       |
| p. |       |       |
| q. |       |       |
| r. |       |       |
| s. |       |       |
| t. |       |       |
| u. |       |       |
| v. |       |       |

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

|  |
| --- |
| **25a. 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 correspondence utilizes 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** |
| **25b. 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)** |       |

|  |
| --- |
| **27a. Physician’s Contact Information and Signature: By signing below, I have reviewed and concur with the above evaluation:** |
| a. | **Prescribing Physician** |       | d. | **Physician NPI** |       |
| b. | **Agency** |       | e. | **Preferred Phone Number** |       |
| c. | **Address** |       |
| **City** |       | **State** |       | **Zip Code** |       |
| **Preferred Email** |       |  **Fax** |       |
| **27b. 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)** |       |

|  |
| --- |
| **\*26. Evaluating Assistive Technology Professional (ATP) signature is required when the ATP provides any technical documentation in #24.**  |
| [ ]  | **ATP’s Signature and Credentials** |       | **Date****(mm/dd/yyyy)** |       |