July 2007

Dear Provider:

Many suppliers, payers and therapists have created evaluation forms for use as a tool for practitioners to evaluate and assess medical needs and conditions relating to mobility. The following form encompasses appropriate elements for practitioners to evaluate and consider when ordering wheeled mobility equipment. This form is not a required element of the medical record or a prior approval submission. Although a practitioner completed form is considered part of the medical record, it is not a substitute for the comprehensive medical record as required in the NYS Medicaid Wheeled Mobility Equipment Guidelines.

If the report of a licensed/certified medical professional (LCMP) (e.g., physical or occupational therapist) examination is to be considered as part of the medical record, there must be a signed and dated attestation by the supplier that the LCMP has no financial relationship with the supplier. A report without such an attestation will not be considered part of the medical record for prior approval or audit purposes.

Comments and suggestions are welcome are welcome in relation to this form or other suggested formats that can be utilized by stakeholders, and can be forwarded to:

Pre-Payment Review Group
150 Broadway Suite 6E
Albany, NY 12203
(Attn: Wheeled Mobility Evaluation Forms)

PATIENT INFORMATION:

Name:	Date seen: Time:	DOB: Sex:
Address:	Physician:	Phone:
Type of Residence:	Seating Therapist:	Phone:
Phone:	Primary Therapist:	Phone:
Background/ Experience of Evaluator / Relationship to Recipient (optional):		
Referred by: (If other than MD) Insurance/Payor: Recipient#:	Equipment Supplier Company: Contact person: Phone:	Caregiver name: Phone Number:
Reason for Referral:		
Patient Goals:		

MEDICAL HISTORY:

Diagnosis:	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:
	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:
	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:

Recent/future surgeries/prognosis:		
Height:	Weight:	Explain recent changes or trends in weight:
Medical History:		
Cardio Status: ❑ Intact ❑ Impaired	Functional Limitations:	
Respiratory Status: ❑ Intact ❑ Impaired	Functional Limitations: Description Required:	
Orthotics: Additional Comments:		

HOME ENVIRONMENT:

❑ House ❑ Condo/town home ❑ Apartment ❑ Asst Living ❑ LTCF ❑Own ❑ Rent		
❑Lives Alone ❑ Lives with Others	Hours without caregiver:	
Entrance: ❑ Level ❑ Stairs ❑ Ramp ❑ Lift	Width of entrance:	Number of floors:
❑ Accessible Bedroom ❑ Accessible Bathroom	Narrowest Doorway to access:	

Non-accessible rooms:
Storage of wheelchair:
Additional Comments:

COMMUNITY ADL:

TRANSPORTATION: ❑ Car ❑ Van ❑ Bus ❑ Adapted w/c Lift ❑ Ambulance ❑ Other:	
Where is w/c stored during transport?	Size of area needed for transportation of w/c: w x d x h.
❑ Self Driver Drive while in Wheelchair ❑ Yes ❑ No	Tie Downs:
Van head clearance: Door _____" Inside _____"	Van door width _____" Ramp lift w_____" x d_____"
# Hours per day/specific requirements pertaining to mobility Employment:	
# Hours per day/specific requirements pertaining to mobility School:	
Other (Support services provided; nursing, aides, attendants):	

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: ❑ Right ❑ Left Comments:	
Functional Processing Skills for Wheeled Mobility ❑ Processing Skills are adequate for safe wheelchair operation	
Areas of concern that may interfere with safe operation of wheelchair	**Description or problem/Plan to ensure safety**
❑ Attention to environment	
❑ Judgment	
❑ Vision or visual processing	
❑ Hearing	
❑ Motor Planning	
❑ Fluctuations in Behavior	

COMMUNICATION:

Verbal Communication ❑ WNL ❑ Understandable ❑ Difficult to understand ❑Non-communicative
❑ Uses an augmentative communication device Manufacturer/Model:
Equipment needs/Mounting:

SENSATION and SKIN ISSUES:

Sensation ❑ Intact ❑ Impaired ❑ Absent Level of sensation:	**Sensory Tactile Processing** ❑ Hyposensate ❑ Hypersensate ❑ Defensiveness <u>Complaint of Pain: Please describe</u>	
Skin Issues/Skin Integrity Current Skin Issues ❑ Yes ❑ No ❑ Intact ❑ Red area ❑ Open area ❑ Scar Tissue ❑ At risk from prolonged sitting Where _____	History of Skin Issues ❑ Yes ❑ No Where _____ When _____	Hx of skin flap surgeries ❑ Yes ❑ No Where _____ When

Comments (include comprehensive plan of care if DME for skin protection / pressure relief):

ADL STATUS (in reference to wheelchair use):

	Indep	Assist	Unable	Indep With Equip	Not Assessed (explain)	Comments
Dressing						
Eating						Describe oral motor skills
Grooming/Hygiene						
Meal Prep						
IADLS						
Bowel Mngmnt: ❑ Continent ❑ Incontinent ❑ Accidents						Comments:
Bladder Mngmt: ❑ Continent ❑ Incontinent ❑ Catheter						Comments:

CURRENT SEATING / MOBILITY:

Current Mobility Base: ❑ None ❑ Dependent ❑ Dependent with Tilt ❑ Manual ❑ Scooter ❑ Power	Type of Control:	
Manufacturer:	Model:	Serial #:
Size:	Color:	Age:

Current Condition of Mobility Base (provide specific repairs needed):	
Current Seating System:	Age of Seating Systems:
COMPONENT	**MANUFACTURER/CONDITION**
Seat Base	
Cushion	
Back	
Lateral trunk supports	
Thigh support	
Knee support	
Foot Support	
Foot strap	
Head support	
Pelvic Stabilization	
Anterior Chest/Shoulder Support	
UE Support	
Other	
Describe Posture in present seating system	

WHEELCHAIR SKILLS:

	Indep	Assist	Unable	N/A	Comments
Bed ↔w/c Chair Transfers	❑	❑	❑	❑	
w/c ↔Commode Transfers	❑	❑	❑	❑	
Manual w/c Propulsion:	❑	❑	❑	❑	One arm: ❑ left ❑ right One foot: ❑ left ❑ right ❑ Both feet ❑ Safe ❑ Functional Distance:
Operate Scooter	❑	❑	❑	❑	❑ Safe ❑Functional Distance:
Operate Power w/c: Std. Joystick	❑	❑	❑	❑	
Operate Power w/c: w/a Alternative	❑	❑	❑	❑	

Able to perform Weight Shifts/		❑	❑	❑	❑	Method:
Bed Confined without w/c	❑ Yes	❑ No	Hours spent sitting in w/c each day:			
Does Mobility Meet Functional Requirement: ❑ Yes ❑ No (if yes, describe in detail):						
Activity Tolerance/Endurance:						
Additional Comments:						

MOBILITY/BALANCE:

Balance		Transfers	Ambulation
Sitting Balance:	Standing balance	❑ Independent	❑ Unable to Ambulate
❑ WFL ❑ Uses UE for support	❑ WFL	❑ Min Assist	❑ Ambulates with assist
❑ Min support	❑ Min support	❑ Max Assist	❑ Ambulates with Device
❑ Mod Support	❑ Mod support	❑ sliding board	❑ Independent without device
❑ Unable	❑ Unable	❑ Lift / Sling Required	❑ Indep. Short Distance Only
Additional Comments:			

MAT EVALUATION:

	o	

	Measurements in sitting:	Left	Right		
	A: Shoulder Width				Seat to axilia
	B: Chest Width			**H:**	Seat to Top of Shoulder
	C: Chest depth (Front – Back)			**I:**	Acromum Process (Tip of shoulder)
	D: Hip Width			**J:**	Inferior Angle of Scapula
	** Asymmetrical Width for windswept legs			**K:**	Seat to elbow
	D: Hip Width			**L:**	Seat to Iliac Crest
	E: Between Knees			**M:**	Upper Leg length
	F: Top of Head			**N:**	Lower Leg Length
	G: Occiput			**O:**	Foot Length

Additional Comments:

** Asymmetrical Width: i.e., windswept or Scoliotic posture: widest point to widest point

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

	POSTURE/TONE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	❑ Functional ❑ Flexed ❑ Extended ❑ Rotated L ❑ Lat flexed L ❑ Rotated R ❑ Lat flexed R ❑ Cervical Hyperextension	❑ Good Head Control ❑ Adequate Head Control ❑ Limited Head Control ❑ Absent Head Control	Describe Tone/Movement of Head and Neck:	Describe in detail:
UPPER EXTREMITY	**SHOULDERS** **Left** **Right** ❑ Functional ❑ Functional ❑ elev / dep ❑ elev / dep ❑ pro-retract ❑ pro-retract ❑ subluxed ❑ subluxed	**R.O.M.** ❑ WNL ❑ WFL Limitations: **Strength concerns:**	Describe Tone/Movement of UE:	Describe in detail:
	ELBOWS **Left** **Right**	**R.O.M.** **Strength concerns:**		
WRIST & HAND	**Left** **Right** ❑ Fisting	**Strength / Dexterity:**		
TRUNK	**ANTERIOR / POSTERIOR** ❑ WFL ❑ ↑ thoracic Kyphosis ❑ ↑ Lumbar Lordosis ❑ Fixed ❑ Flexible ❑ Partly Flexible ❑ Other	**Left Right** Degree of curvature: _____° ❑ WFL ❑ Convex Left ❑ Convex Right ❑ c-curve ❑ s-curve ❑ multiple ❑ Fixed ❑ Flexible ❑ Partly Flexible ❑ Other	**Rotation-shoulders and upper trunk** ❑ Neutral ❑ Left-anterior ❑ Right-anterior ❑ Fixed ❑ Flexible ❑ Partly Flexible ❑ Other	Describe in detail:
PELVIS	**Anterior / Posterior** ❑ Neutral ❑ Posterior ❑ Anterior ❑ Fixed ❑ Other ❑ Partly Flexible ❑ Flexible	**Obliquity** ❑ WFL ❑ R elev ❑ L elev ❑ Fixed ❑ Other ❑ Partly Flexible ❑ Flexible	**Anterior / Posterior** ❑ WFL ❑ Right Anterior ❑ Left Anterior ❑ Fixed ❑ Other ❑ Partly Flexible ❑ Flexible	Describe in detail:

	POSTURE/TONE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
H I P S	**Position** ❑ Neutral ❑ ABduct ❑ ADduct ❑ Fixed ❑ subluxed ❑ Partly Flexible ❑dislocated ❑ Flexible	**Windswept** ❑ Neutral ❑ Right ❑ Left ❑ Fixed ❑ Other ❑ Partly Flexible ❑ Flexible	**Range of Motion** **Left Right** WNL Adequate for sitting Limitations	Describe in detail:
KNEES & FEET	**Knee R.O.M.** **Left** **Right** ❑ WFL ❑ WFL ❑ Limitations Describe: ❑ Limitations Describe:	Strength concerns: Knee/Hamstring positioning needs:	**Foot Position** ❑ WFL ❑ L ❑ R ROM concerns: Dorsi-Flexed ❑ L ❑ R Plantar Flexed ❑ L ❑ R Inversion: ❑ L ❑ R Eversion ❑ L ❑ R	Foot Positioning Needs: ❑ orthotics

Additional Comments:

Goals for Mobility Base
Goals for Seating System
Simulation Ideas/Equipment trials/State why other equipment was unsuccessful (including but not limited to less costly alternatives explored):

MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION

MOBILITY BASE	JUSTIFICATION	
General Info ❑ Dependent ❑ Manual ❑ Power ❑ Scooter Power control ❑ R ❑ L Other: Color:	See specifics below	
Manufacturer: **Model:** Size: width Seat depth Back Height	❑ provide transport from point A to B ❑ promote indep mobility ❑ is not a safe, functional ambulatory ❑	
Stroller base	❑ infant child ❑ unable to propel manual wheelchair ❑ allows for growth	❑ non-functional ambulatory ❑ less costly/medically appropriate alternatives explored.
Manual Mobility Base CODE:	❑ non-functional ambulator ❑	
Push handles ❑ angle adjustable ❑ extended ❑standard (no justification needed)	Describe Medical need:	
Lighter weight required	❑self propulsion ❑ lifting (by recipient)	❑
Heavy Duty required	❑ user weight greater than 250 pounds (see manual for parameters) ❑ extreme tone ❑ over active	❑ broken frame on previous chair ❑ multiple seat functions ❑
Specific seat height required Floor to seat height	❑ foot propulsion ❑ transfers ❑ accommodation of leg length	❑ access to table or desk top ❑
Rear wheel placement / Axle adjustability ❑ None ❑ semi adjustable ❑ fully adjustable	❑ improved UE access to wheels ❑ improved stability ❑ changing angle in space for improvement with postural	❑ stability ❑ 1-arm drive access ❑ amputee placement ❑
Angle Adjustable Back	❑ postural control ❑ control of tone/spasticity ❑ accommodation of range of motion	❑ UE functional control ❑ accommodation for seating system ❑
Tilt Base or added **❑ Forward ❑ Backward** CODE:	❑ change position against gravitational force on head and shoulders ❑ change position for pressure relief/can not weight shift	❑ management of tone ❑ facilitate postural control ❑
Recline Base CODE:	❑ accommodate femur to back angle ❑ change position for pressure relief/can not weight shift ❑ head positioning	❑ repositioning for transfers or catheter changes ❑
Scooter/POV CODE:	❑ can safely operate ❑ can safely transfer	❑ has adequate trunk stability ❑can not propel wheelchair (any type) ❑

MOBILITY BASE	JUSTIFICATION	
Power Mobility Base CODE:	❑ non-ambulatory ❑ can not propel manual wheelchair	❑
W/C controls Body Part _____ ❑ Proportional ❑ Non-Proportional/Switches ❑ Electronic ❑ Mechanical Manufacturer/Model: CODE:	❑ provides access for controlling wheelchair ❑ safety	❑ power tilt or recline ❑ programming for accurate control ❑
Hangers/ Leg rests ❑ 70 ❑ 90 ❑ elevating ❑ articulating ❑ fixed ❑ lift off ❑ swing away ❑ rotational hanger brackets ❑ adjustable knee angle ❑ recessed calf panel ❑ heavy duty ❑ other CODE:	❑ provide LE support ❑ accommodate to hamstring tightness ❑ elevate legs during recline ❑ provide change in position for Les	❑ durability ❑ enable transfers ❑ decrease edema ❑
Foot support ❑ adjustable Footplate ❑ R ❑ L ❑ flip up ❑ depth adjustable CODE:	❑ provide foot support ❑ accommodate to ankle ROM ❑allow foot to go under wheelchair base	❑ transfers ❑
Armrests ❑ fixed ❑ adjustable height ❑ removable ❑ swing away ❑ flip back ❑ reclining ❑ full length pads ❑ desk ❑ pads tubular CODE:	❑ provide support with elbow at 90 ❑ provide support for w/c tray ❑ change height/angles for medical necessity.	❑ remove for transfers ❑ allow to come closer to table top ❑ remove for access to tables ❑
Wheel size: **Style** ❑ mag ❑ spokes ❑	❑ increase access to wheel ❑ allow for seating system to fit on base	❑ increase propulsion ability ❑ maintenance ❑
Quick Release wheels	❑ allows wheels to be removed to transport ❑ decrease width of w/c for storage	❑ decrease weight for lifting ❑
Wheel rims/hand rims CODE: ❑ metal ❑ plastic coated ❑ vertical projections ❑ oblique projections	❑ provide ability to propel manual wheelchair for individual with hand weakness/decreased grasp	Describe in detail:
Tires: ❑ pneumatic ❑ flat free inserts ❑ solid CODE:	❑ decrease maintenance ❑ prevent frequent flats ❑ increase shock absorbency	❑ decrease pain from road shock ❑ decrease spasms from road shock ❑
Caster housing: **Caster size:** **Style:**	❑ maneuverability ❑ stability of wheelchair ❑ increase shock absorbency ❑ durability ❑ maintenance ❑ angle adjustment for posture	❑ decrease pain from road shock ❑ decrease spasms from road shock ❑ allow for feet to come under wheelchair base ❑allows change in seat to floor height ❑
Spoke Protector CODE:	❑ prevent hands from getting caught in spokes	❑
Shock absorbers CODE:	❑ decrease vibration ❑ Specific medical condition, explain in history:	❑provide smoother ride over rough terrain

MOBILITY BASE	JUSTIFICATION	
One armed device ❑ Left ❑ Right CODE:	❑enable propulsion of manual wheelchair with one arm	❑ unable to propel assisting with feet ❑
Anti-tippers CODE:	❑ prevent wheelchair from tipping backward	❑
Battery CODE:	❑ power motor on wheelchair	
Charger	❑ charge battery for wheelchair	
Ventilator tray CODE:	❑ stabilize ventilatory on wheelchair	
Amputee adapter CODE:	❑ provide support for stump/residual extremity	
Crutch/cane holder CODE: **IV hanger CODE:**	❑ stabilize accessory on wheelchair	
Brake/wheel lock extension ❑ R ❑ L		❑ increase indep in applying wheel locks
Other:		
Other:		

Additional Comments:

SEATING COMPONENT RECOMMENDATIONS and JUSTIFICATION

Component	Manufacturer	Model	Size	Justification
Seat Cushion CODE:				❑ stabilize pelvis ❑ accommodate obliquity ❑ accommodate multiple deformity ❑ neutralize LE ❑ increase pressure distribution ❑ accommodate impaired sensation ❑ decubitus ulcers present ❑ prevent pelvic extension ❑ low maintenance ❑
Cover Replacement CODE:				❑ protect back or seat cushion ❑
Seat Platform CODE:				❑ support cushion to prevent hammocking ❑
Back CODE:				❑ provide posterior trunk support ❑ provide lumbar/sacral support ❑ support trunk in midline ❑ provide lateral trunk support ❑ accommodate deformity ❑ accommodate or decrease tone ❑ facilitate tone ❑
Additional pieces to seat or back cushion				
Mounting hardware ❑ lateral trunk supports ❑ headrest ❑ medial thigh support ❑ joystick	❑ fixed ❑ swing away CODE:			❑ attach seat platform/cushion to w/c frame ❑ attach back cushion to w/c frame ❑ swing joystick out of the way ❑ swing headrest away ❑ swing medial thigh support away ❑
Lateral pelvis/thigh support CODE:				❑ pelvis in neutral ❑ accommodate pelvis ❑ position upper legs ❑ accommodate tone ❑ removable for transfers ❑
Medial Knee Support CODE:				❑ decrease adduction ❑accommodate ROM ❑ remove for transfers ❑ alignment ❑
Foot Support CODE:				❑ position foot ❑ accommodate deformity ❑ stability ❑ decrease tone ❑ control position
Ankle strap/heel loops CODE:				❑ support foot on foot support ❑ decrease extraneous movement ❑ provide input to heel ❑ protect foot ❑
Lateral trunk supports CODE:			❑ R ❑ L	❑ decrease lateral trunk leaning ❑ accom asymmetry ❑ contour for increased contact ❑ safety ❑ control of tone ❑
Anterior chest or shoulder supports CODE:				❑ decrease forward movement of trunk ❑ decrease forward movement of shoulders ❑ decrease shoulder elevation ❑ accommodation of TLSO ❑ added abdominal support ❑ alignment ❑ assistance with shoulder control ❑

Headrest CODE:				❑ provide posterior head support ❑ provide posterior neck support ❑ provide lateral head support ❑ provide anterior head support ❑ support during tilt and recline ❑ improve feeding ❑ improve respiration ❑ placement of switches ❑ safety ❑ accommodate ROM ❑ accommodate tone ❑ improve visual orientation ❑
Neck Support CODE:				❑ decrease forward neck flexion ❑ decrease neck rotation
Upper Extremity Support CODE:			❑ R ❑ L	❑ decrease gravitational pull on shoulders ❑ provide midline positioning ❑ provide support to increase UE function ❑ decrease edema ❑ decrease subluxation ❑ control tone ❑
Pelvic Positioner CODE:				❑ stabilize tone ❑ decrease falling out of chair/ **will not decrease potential for sliding due to pelvic tilting ❑ prevent excessive rotation ❑ pad for protection over boney prominence ❑ prominence comfort ❑ special pull angle to control rotation ❑
Other				

Additional Comments:

Patient/Client Name Printed:		
Patient/client/Caregiver Signature:		**Date:**
Therapist Name, Address & Phone Printed:		
Therapist's Signature:		**Date:**
Supplier's Name, Address & Phone Printed:		
Supplier's Signature:		**Date:**

I agree with the above findings and recommendations of the therapist and supplier:

Physician's Name Printed:		
Physician's Signature:		**Date:**
Physician Address:		
Physician Phone:		