Home Evaluation Form

Save

Patient Name:

Address:

Phone:

Type of Mobility Assistive Equipment (MAE):

☐ Manual Chair ☐ POV/Scooter ☐ Power Wheelchair

Type of Home:

☐ Single Story ☐ Multi-Story ☐ Apt./Condo ☐ Mobile Home

Accessible? ☐ Yes ☐ No ☐ Recommendations

Equipment Trials (make, model, turning radius): If Applicable

Home Environment:

☐ The home has standard size doorways.

☐ The bathroom has standard size doorways.

☐ There are obstacles (stairs, thresholds, floor surfaces) in the home that prevent accessibility to doorways, hallways, and rooms.

☐ There is a caregiver that provides assistance. How many hours per day?

Who is the caregiver? ☐ Spouse ☐ Child ☐ Nurse

☐ There are limitations to the caregiver(s) abilities.

If limitations exist, please give details:

Home Environment:

I have completed an assessment of the patient's home and conclude based upon the information above that the patient's home will accommodate the following MAE(s): (Check all that apply)

☐ Manual Chair ☐ POV/Scooter ☐ Power Wheelchair

Supplier Signature: _____ Date: _____