Save

Patient Name:

SS# DOB:

Sex: Date of Evaluation:

Referring Physician:

Therapist:

Wheelchair/Seating Evaluation

Diagnosis: Date of Onset:

Cardio:

Bowels:

Bladder:

Vision:

Auditory:

Cognitive:

Skin Condition:

Sensation:

Muscle Strength UE: Muscle Strength LE: Muscle Strength Trunk:

ROM UE Right: ROM LE Right:

ROM UE Left: ROM LE Left:

Muscle Tone UE Right: Muscle Tone LE Right:

Muscle Tone UE Left: Muscle Tone LE Left:

Ambulation:

Transfers:

W/C Propulsion Ability:

Sitting Balance:

Head Control:

Caregivers:

ADL's:

Scoliosis:

Kyphosis:

Lordosis:

Pelvic Obliquity:

Pelvic Tilt-Post:

Anterior Pelvic Tilt:

Pulmonary Status:

Other Information:

☐ Patient Has Existing Wheelchair

Existing Wheelchair Age: ☐ Make: ☐ Model: ☐

Reason Equipment is Not Appropriate: ☐

Transportation: ☐ ☐ Patient Does Drive

Are there future transportation issues: ☐

Patient Activities: ☐

Is the patient employed? ☐

Does the patient attend school? ☐

Has other equipment been tried, and if so why was it ruled out:

☐

If Power Chair is being sold:

☐ The patient lives alone

If No, who would maintain wet cell batteries? ☐

☐ Sidewalks ☐ Ramped Entrance ☐ Doorways Accessible

☐ Stairs ☐ Bathroom Accessible

How many hours per day will the client be seated in the wheelchair: ☐

☐ Client lives in medical facility Date Admitted: ☐ Potential for discharge: ☐

What is the home environment? ☐

☐ Client requires a loaner wheelchair

Required features of loaner wheelchair? ☐

Notes: ☐

Equipment Required: ☐ Power Chair ☐ Ultralight Chair ☐ Tilt in Space ☐ Custom Back

Recommendations:

☐