

# Seating/Mobility Evaluation

Name: _____	Date Referred: _____	Date of Eval: _____
Address: _____	Phone: _____	Physician: _____
Funding: _____	Age: _____ Sex: _____	OT: _____
Referred By: _____	Height: _____	PT: _____
	Weight: _____	Soc. Sec. No: _____
Reason for Referral: _____		
Patient Goals: _____		
Caregiver Goals: _____		

## MEDICAL HISTORY:

Dx: _____	ICD-9: _____	ICD-9: _____	ICD-9: _____	ICD-9: _____
Hx / Progression: _____				
Recent / Planned Surgeries: _____				
Cardio-Respiratory Status: _____		Comments: _____		
<input type="checkbox"/> Intact: <input type="checkbox"/> Impaired:				

## CURRENT SEATING / MOBILITY: (Type – Manufacturer – Model)

Chair: _____	Age: _____
w/c Cushion: _____	Age: _____
w/c Back: _____	Age: _____
Reason for <input type="checkbox"/> Replacement / <input type="checkbox"/> Repair / <input type="checkbox"/> Update: _____	
Funding Source: _____	

## HOME ENVIRONMENT:

<input type="checkbox"/> House		<input type="checkbox"/> Apt		<input type="checkbox"/> Asst Living		<input type="checkbox"/> LTCF		<input type="checkbox"/> Alone		<input type="checkbox"/> w/ Family-Caregivers:	
Entrance: <input type="checkbox"/> Level		<input type="checkbox"/> Ramp		<input type="checkbox"/> Lift		<input type="checkbox"/> Stairs		Entrance Width: _____			
w/c Accessible Rooms: <input type="checkbox"/> Yes		<input type="checkbox"/> No		Narrowest Doorway Required to Access: _____							
Comments: _____											

## COMMUNITY ADL:

TRANSPORTATION: <input type="checkbox"/> Car	<input type="checkbox"/> Van	<input type="checkbox"/> Bus	<input type="checkbox"/> Adapted w/c Lift	<input type="checkbox"/> Ramp	<input type="checkbox"/> Ambulance	<input type="checkbox"/> Other:
Driving Requirements: _____						
Employment / Educational Requirements: _____						
Other: _____						

## COGNITIVE / VISUAL STATUS:

Memory Skills	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments: _____
Problem Solving	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments: _____
Judgment	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments: _____
Attn / Concentration	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments: _____
Vision:	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments: _____
Hearing:	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments: _____
Other:	<input type="checkbox"/> Intact:	<input type="checkbox"/> Impaired:	Comments: _____

Continued

# Seating/Mobility Evaluation Continued

ADL STATUS:	Indep	Assist	Unable	Comments / Other AT Equipment Required
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming/Hygiene:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meal Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Home Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bowel Management:	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent			
Bladder Management:	<input type="checkbox"/> Continent <input type="checkbox"/> Incontinent			

MOBILITY SKILLS:	Indep	Assist	Unable	N/A	Comments
Bed ↔ w/c Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
w/c ↔ Commode Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ambulation:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Device:
Manual w/c Propulsion:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Perform Weight Shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type:
Hours Spent Sitting in w/c Each Day:	Comments:				

SENSATION:		
<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Absent
Hx of Pressure Sores <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Pressure Sores <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:		




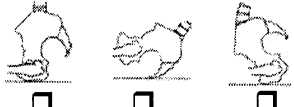
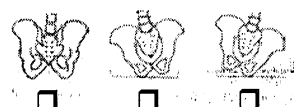

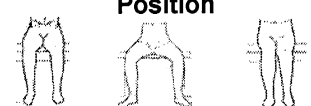


CLINICAL CRITERIA / ALGORITHM SUMMARY	
Is there a mobility limitation causing an inability to safely participate in one or more Mobility Related Activities of Daily Living in a reasonable time frame? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there cognitive or sensory deficits (awareness / judgement / vision / etc) that limit the users ability to safely participate in one or more MRADL's/ADL's?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL's?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:	
Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:	
Can the mobility deficit be sufficiently resolved with only the use of a cane or walker?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:	
Does the user's environment support the use of a <input type="checkbox"/> MANUAL WHEELCHAIR <input type="checkbox"/> POV <input type="checkbox"/> POWER WHEELCHAIR:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:	
If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Explain:	
If a POV is recommended, does the user have sufficient stability and upperextremity function to operate it?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Explain:	
If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Explain:	

RECOMMENDATION / GOALS:
<input type="checkbox"/> MANUAL WHEELCHAIR <input type="checkbox"/> POV <input type="checkbox"/> POWER WHEELCHAIR: <input type="checkbox"/> POSITIONING SYSTEM(TILT/RECLINE/ELEV/STANDING) <input type="checkbox"/> SEATING

Physical / Occupational Therapist: _____	Date: _____	Phone: _____
Physician: I have read & concur with the above assessment	Date: _____	Phone: _____

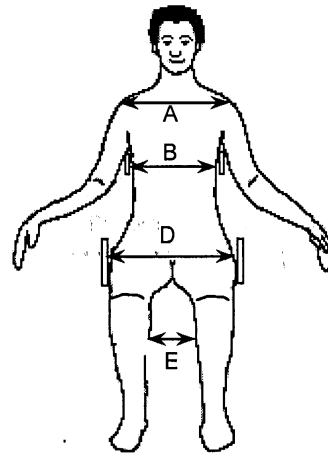
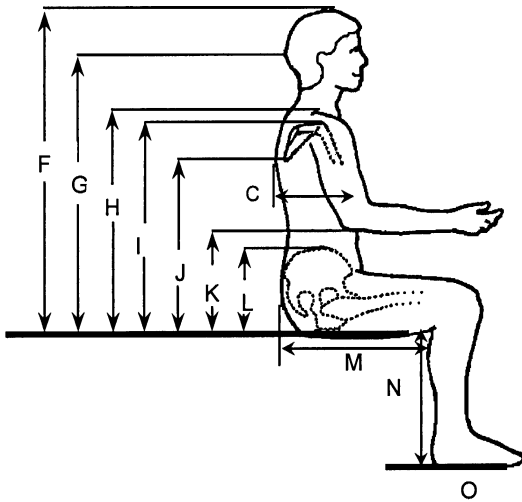
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# Mat Evaluation: (NOTE IF ASSESSED SITTING OR SUPINE)

	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
<b>HEAD &amp; NECK</b>	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated <input type="checkbox"/> Laterally Flexed <input type="checkbox"/> Cervical Hyperextension	<input type="checkbox"/> Good Head Control <input type="checkbox"/> Adequate Head Control <input type="checkbox"/> Limited Head Control <input type="checkbox"/> Absent Head Control		
<b>U P P E R I T Y</b>	<b>SHOULDERS</b> <b>Left</b> <b>Right</b> <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> elev / dep <input type="checkbox"/> elev / dep <input type="checkbox"/> pro / retract <input type="checkbox"/> pro / retract <input type="checkbox"/> subluxed <input type="checkbox"/> subluxed	<b>R.O.M.</b>  <b>Strength:</b>		
	<b>ELBOWS</b> <b>Left</b> <b>Right</b> <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired  <input type="checkbox"/> WFL <input type="checkbox"/> WFL	<b>R.O.M.</b>  <b>Strength:</b>		
<b>WRIST &amp; HAND</b>	<b>Left</b> <b>Right</b> <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	<b>Strength / Dexterity:</b>		
<b>T R U N K</b>	<b>Anterior / Posterior</b>  <input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic Kyphosis <input type="checkbox"/> ↑ Lumbar Lordosis  <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	<b>Left Right</b>  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right  <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	<b>Rotation</b>  <input type="checkbox"/> Neutral <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward  <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	
<b>P E L V I S</b>	<b>Anterior / Posterior</b>  <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior  <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	<b>Obliquity</b>  <input type="checkbox"/> WFL <input type="checkbox"/> Left Lower <input type="checkbox"/> Rt. Lower  <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	<b>Rotation</b>  <input type="checkbox"/> WFL <input type="checkbox"/> Right <input type="checkbox"/> Left  <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	
<b>H I P S</b>	<b>Position</b>  <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct  <input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible	<b>Windswept</b>  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left  <input type="checkbox"/> Fixed <input type="checkbox"/> Other <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Flexible	<b>Range of Motion</b>  <b>Left</b> <b>Right</b> Flex: _____ °    _____ ° Ext: _____ °    _____ °  Int R: _____ °    _____ ° Ext R: _____ °    _____ °	

# Mat Evaluation: Cont'd

<b>KNEES &amp; FEET</b>	<b>Knee R.O.M.</b>		Strength:  Hamstring ROM Limitations: (Measured at ___° Hip Flex) Left _____ Right _____	<b>Foot Positioning</b>		Foot Positioning Needs:
	<u>Left</u>	<u>Right</u>		<input type="checkbox"/> WFL	<input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> WFL	<input type="checkbox"/> WFL		<input type="checkbox"/> Dorsi-Flexed	<input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> Flex _____°	<input type="checkbox"/> Flex _____°		<input type="checkbox"/> Plantar Flexed	<input type="checkbox"/> L <input type="checkbox"/> R	
	<input type="checkbox"/> Ext _____°	<input type="checkbox"/> Ext _____°		<input type="checkbox"/> Inversion	<input type="checkbox"/> L <input type="checkbox"/> R	
				<input type="checkbox"/> Eversion	<input type="checkbox"/> L <input type="checkbox"/> R	
<b>MOBILITY</b>	<b>Balance</b>		<b>Transfers</b>	<b>Ambulation</b>		
	Sitting Balance:	Standing Balance:		<input type="checkbox"/> Independent	<input type="checkbox"/> Unable to Ambulate	
	<input type="checkbox"/> WFL	<input type="checkbox"/> WFL	<input type="checkbox"/> Min Assist	<input type="checkbox"/> Ambulates with Assistance		
	<input type="checkbox"/> Min Support	<input type="checkbox"/> Min Support	<input type="checkbox"/> Max Asst	<input type="checkbox"/> Ambulates with Device		
	<input type="checkbox"/> Mod Support	<input type="checkbox"/> Mod Support	<input type="checkbox"/> Sliding Board	<input type="checkbox"/> Independent without Device		
	<input type="checkbox"/> Unable	<input type="checkbox"/> Unable	<input type="checkbox"/> Lift / Sling Required	<input type="checkbox"/> Indep. Short Distance Only		



**Neuro-Muscular Status:**

Tone:

Reflexive Responses:

Effect on Function:

Measurements in Sitting:		Left	Right	
A:	Shoulder Width			Degree of Hip Flexion
B:	Chest Width			H: Top of Shoulder
C:	Chest Depth (Front - Back)			I: Acromium Process (Tip of Shoulder)
D:	Hip Width			J: Inferior Angle of Scapula
**	Asymmetrical Width			K: Elbow
D:	Hip Width			L: Iliac Crest
E:	Between Knees			M: Sacrum to Popliteal Fossa
F:	Top of Head			N: Knee to Heel
G:	Occiput			O: Foot Length

Additional Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*\* Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point

Physical / Occupational Therapist: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: I have read & concur with the above assessment \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

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