

Seating/Mobility Evaluation

Required attachment to the Alabama Medicaid Prior Review and Authorization Form (Form342). This form must be completed by an Alabama licensed Physical Therapist/Occupational Therapist employed by an enrolled Medicaid Hospital through the hospital outpatient department. This is the only way Alabama Medicaid will reimburse for the physical therapy evaluation for motorized power wheelchairs.

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: _____
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: _____

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? If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL's? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the user's environment support the use of a <input type="checkbox"/> MANUAL WHEELCHAIR <input type="checkbox"/> POV <input type="checkbox"/> POWER WHEELCHAIR? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If a POV is recommended, does the user have sufficient stability and upperextremity function to operate it? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? Explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

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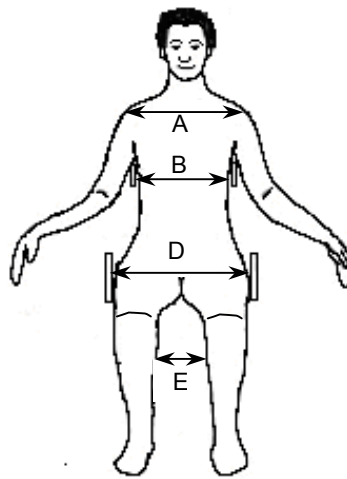
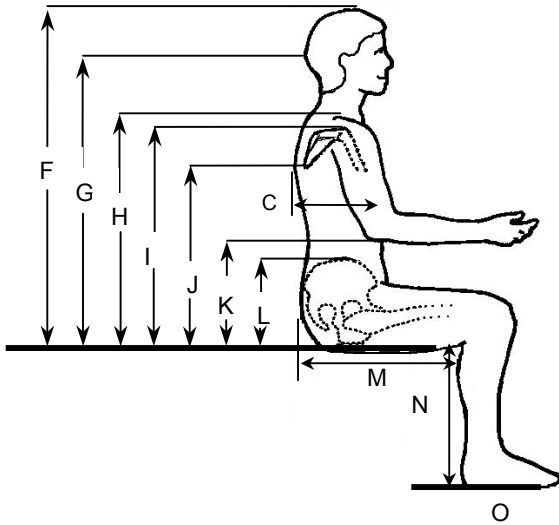
Physical / Occupational Therapist: _____	Date: _____	Phone: _____
Physician: I have read & concur with the above assessment _____	Date: _____	Phone: _____

Mat Evaluation: (NOTE IF ASSESSED SITTING OR SUPINE)

	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	<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		
EXTREMITY	SHOULDERS Left Right <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	R.O.M. Strength:		
	ELBOWS Left Right <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	R.O.M. Strength:		
WRIST & HAND	Left Right <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	Strength / Dexterity:		
TRUNK	Anterior / Posterior  <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	Left Right  <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	Rotation  <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	
PELVIS	Anterior / Posterior  <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	Obliquity  <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	Rotation  <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	
HIPS	Position  <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	Windswept  <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	Range of Motion  Left Right Flex: _____ ° _____ ° Ext: _____ ° _____ ° Int R: _____ ° _____ ° Ext R: _____ ° _____ °	

Mat Evaluation: Cont'd

KNEES & FEET	Knee R.O.M.		Strength: Hamstring ROM Limitations: (Measured at ___° Hip Flex) Left _____ Right _____	Foot Positioning		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	
MOBILITY	Balance		Transfers	Ambulation		
	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		
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: _____