

Date: \_\_\_\_\_

**\* Please attach completed *Power Mobility Skills Checklist (05.34)* to this questionnaire.**

**SECTION I—PATIENT INFORMATION**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

What type of environment does the child reside in (e.g.: single story home, an apartment complex); how will the power chair access this environment? Please give full detail:

\_\_\_\_\_  
\_\_\_\_\_

**SECTION II—MEDICAL HISTORY**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date or onset of condition/injury requiring use of mobility device: \_\_\_\_\_

Diagnosis(es) *(please include written description and ICD-9 Codes)*: \_\_\_\_\_

\_\_\_\_\_

How has the child's condition progressed to now requiring power mobility? \_\_\_\_\_

\_\_\_\_\_

Child's current ambulatory status *(please include any assistive device, physical assistance and degree of assistance required)*: \_\_\_\_\_

Child's current ability to perform activities of daily living (ADL) in home and other environments; how will this chair improve the child's ability to perform ADL independently *(please include any assistive device, physical assistance and degree of assistance required)*: \_\_\_\_\_

\_\_\_\_\_

***Does the child currently have a mobility device?***

Yes       No

If yes, list: Make: \_\_\_\_\_ Model: \_\_\_\_\_ Age of Equipment: \_\_\_\_\_

***Functional status (please provide quantitative measurements):***

ROM limitations: \_\_\_\_\_

Muscle strength limitations: \_\_\_\_\_

Upper extremity function: \_\_\_\_\_

## SECTION II—MEDICAL HISTORY (Cont'd)

Lower extremity function: \_\_\_\_\_

Ability to transfer: \_\_\_\_\_

Endurance: \_\_\_\_\_

Communication (*is an augmentative communication device used*)? \_\_\_\_\_

## SECTION III—PHYSICAL ASSESSMENT

Sitting posture/balance: \_\_\_\_\_

Pelvic tilt/obliquity/rotation: \_\_\_\_\_

Leg position: \_\_\_\_\_

Scoliosis: \_\_\_\_\_

Lordosis/kyphosis: \_\_\_\_\_

Head position: \_\_\_\_\_

Shoulder/scapula position: \_\_\_\_\_

Movement/strength: \_\_\_\_\_

Tone/spasms: \_\_\_\_\_

Skeletal/physical limitations/deformities/abnormalities: \_\_\_\_\_

Respiratory status: \_\_\_\_\_

### ***Skin Condition/Integrity***

Susceptible to decubitus ulcers?  Yes  No

If yes, explain: \_\_\_\_\_

Sensation: \_\_\_\_\_

Present/history of ulcers: \_\_\_\_\_

Location(s): \_\_\_\_\_

Stage: \_\_\_\_\_

Ability to perform pressure relief: \_\_\_\_\_

Bowel/bladder status (toileting): \_\_\_\_\_

**SECTION IV—ADDITIONAL QUESTIONS FOR MEDICAL NECESSITY \***

Has the child been evaluated using the power wheelchair in the home? \_\_\_\_\_

Have any barriers been identified for use of a power wheelchair in the home (e.g.; front door entrance, hallways, van)?

Yes                       No

If yes, please describe barrier(s) and how it/they will be addressed: \_\_\_\_\_

Where will the child primarily use the equipment? \_\_\_\_\_

How will the power wheelchair be transported to and from medical visits? \_\_\_\_\_

Rationale and benefits of power mobility for this child: \_\_\_\_\_

What other mobility devices were considered? Please list type and reason why a less expensive device is not sufficient to meet child's needs: \_\_\_\_\_

**Recommendations:**

Mobility base – specify make/model: \_\_\_\_\_

Option – specify each option/accessory and why the item is required for this child: \_\_\_\_\_

Seating—specify special seating components, including supports and why the item is required for this child:

**Vendor Information:**

Equipment Supplier: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**SIGNATURE(S)**

***I have reviewed Sections I, II, III and IV of this clinical assessment and agree that it is an accurate assessment of the client and their needs.***

Therapist's Name: \_\_\_\_\_  
(Please print) Phone #: Fax #

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

Physician's Name: \_\_\_\_\_  
(Please print) Phone #: Fax #

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature)

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