Custom Wheelchair Evaluation

The intent of this form is to secure sufficient information to determine the medical necessity for a custom wheelchair request submitted for prior approval to Florida Medicaid.
This form must be completed by the licensed therapist or the certified physiatrist performing the evaluation.
The evaluator may choose to include additional information that substantiates medical necessity for the equipment requested.

Recipient Name:	Date Referred:	Date of Evaluation:	
Address:	Phone:	Physician:	
	Age: Sex:	OT:	
Funding:	Date of Birth:	PT:	
Referred By:	Height:		
	Weight:		
Medicaid ID #			

Reason for Referral:

Patient Goals:

Caregiver Goals:

MEDICAL HISTORY:

Dx: ICD-9:_____ ICD-9:_____ ICD-9:_____ ICD-9:_____

Date of injury/onset:

Prognosis/ Hx:

Recent / Planned Surgeries:

Cardio-Respiratory Status: ☐ Intact ☐ Impaired	Comments:

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

Chair: Age:

Serial #

w/c Cushion: Age:	**w/c Back**: Age:

Other Positioning Components:

Reason for ☐ Replacement / ☐ Repair / ☐ Update:

Funding Source:

HOME ENVIRONMENT:

☐ House ☐ Apt ☐ Asst Living ☐ LTCF ☐ Alone ☐ w/ Family-Caregivers:

Length of time at residence:

Entrance: ☐ Level	☐ Ramp	☐ Lift	☐ Stairs	Entrance Width:

w/c Accessible Rooms:	☐ Yes	☐ No	Narrowest Doorway Required to Access:
Is a caregiver available 24 hours a day:	☐ Yes	☐ No	If no, how many hours a day is a caregiver available?

Comments:

TRANSPORTATION: ☐ Car ☐ Van ☐ Bus ☐ Adapted w/c Lift ☐ Ramp ☐ Ambulance ☐ Other:

COGNITIVE / VISUAL STATUS:

Memory Skills	☐ Intact:	☐ Impaired:	Comments:
Problem Solving	☐ Intact:	☐ Impaired:	Comments:
Judgment	☐ Intact:	☐ Impaired:	Comments:
Attn / Concentration	☐ Intact:	☐ Impaired:	Comments:
Vision	☐ Intact:	☐ Impaired:	Comments:
Hearing	☐ Intact:	☐ Impaired:	Comments:
Other	☐ Intact:	☐ Impaired:	Comments:

ADL STATUS:	Indep	Assist	Unable	Comments / Other AT Equipment Required
Dressing	☐	☐	☐	
Bathing	☐	☐	☐	
Feeding	☐	☐	☐	
Grooming/Hygiene	☐	☐	☐	
Toileting	☐	☐	☐	
Meal Prep	☐	☐	☐	
Home Management	☐	☐	☐	
Bowel Management:	☐ Continent	☐ Incontinent		
Bladder Management:	☐ Continent	☐ Incontinent		

MOBILITY SKILLS:	Indep	Assist	Unable	N/A	Comments
Bed ↔ w/c Transfers	☐	☐	☐	☐	
w/c ↔ Commode Transfers	☐	☐	☐	☐	
Ambulation:	☐	☐	☐	☐	Device:
Manual w/c Propulsion:	☐	☐	☐	☐	
Operate Power w/c w/ Std. Joystick	☐	☐	☐	☐	
Operate Power w/c w/ Alternative Controls	☐	☐	☐	☐	
Ability to Stand	☐	☐	☐	☐	
Able to Perform Weight Shifts	☐	☐	☐	☐	Type:
Hours Spent Sitting in w/c Each Day:			Comments:		

SENSATION:

☐ Intact ☐ Impaired ☐ Absent | Hx of Pressure Sores ☐ Yes ☐ No

Current Pressure Sores ☐ Yes ☐ No Location/Stage

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: ☐ Yes ☐ No

Are there cognitive or sensory deficits (awareness / judgment / vision / etc) that limit the users' ability to safely participate in one or more MRADL's or ADL's? ☐ Yes ☐ No

If yes, can they be accommodated / compensated for to allow use of a mobility assistive device to participate in MRADL's? ☐ Yes ☐ No

Explain:

Does the user demonstrate the ability or potential ability and willingness to safely use the mobility assistive device? ☐ Yes ☐ No

Explain:

Can the mobility deficit be sufficiently resolved with only the use of a cane or walker? ☐ Yes ☐ No

Explain:

Does the user's environment support the use of a ☐ MANUAL WHEELCHAIR ☐ POV ☐ POWER WHEELCHAIR: ☐ Yes ☐ No

Explain:

If a manual wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? ☐ Yes ☐ No ☐ N/A

Explain:

If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it? ☐Yes ☐No ☐N/A

Explain:

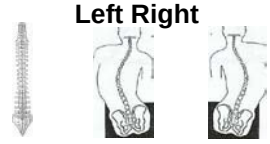
If a power wheelchair is recommended, does the user have sufficient function/abilities to use the recommended equipment? ☐Yes ☐No ☐N/A

Explain:

RECOMMENDATION / GOALS:

☐ **MANUAL** WHEELCHAIR ☐ **POV** ☐**POWER WHEELCHAIR:** ☐**POSITIONING SYSTEM**(TILT/RECLINE) ☐**SEATING**

Mat Evaluation: (NOTE IF ASSESSED SITTING OR SUPINE)

	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT NEEDED
HEAD & NECK	☐ Functional ☐ Flexed ☐ Extended ☐ Rotated ☐ Laterally Flexed ☐ Cervical Hyperextension	☐ Good Head Control ☐ Adequate Head Control ☐ Limited Head Control ☐ Absent Head Control ☐ Tone/ Reflex		
UPPER EXTREMITY	**SHOULDERS** **Left** / **Right** ☐WFL ☐WFL ☐elev / dep ☐elev / dep ☐pro / retract ☐pro / retract ☐subluxed ☐subluxed	**R.O.M.** **Strength:** **Tone/Reflex:**		
	ELBOWS **Left** / **Right** ☐Impaired ☐Impaired ☐WFL ☐WFL	**R.O.M.** **Strength:** **Tone/Reflex:**		
WRIST & HAND	**Left** / **Right** ☐Impaired ☐Impaired ☐WFL ☐WFL	**Strength / Dexterity:**		
TRUNK	**Anterior / Posterior**  ☐ WFL ☐ ↑ Thoracic Kyphosis ☐ ↑ Lumbar Lordosis ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Left Right**  ☐ WFL ☐ Convex Left ☐ Convex Right ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	**Rotation**  ☐ Neutral ☐ Left Forward ☐ Right Forward ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	

PELVIS

Anterior / Posterior

☐ Neutral ☐ Posterior ☐ Anterior

☐ Fixed ☐ Other
☐ Partly Flexible
☐ Flexible

Obliquity

☐ WFL ☐ Left Lower ☐ Rt. Lower

☐ Fixed ☐ Other
☐ Partly Flexible
☐ Flexible

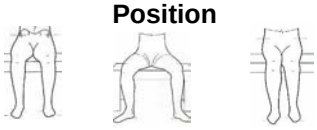
Rotation

☐ WFL ☐ Right ☐ Left

☐ Fixed ☐ Other
☐ Partly Flexible
☐ Flexible

HIPS

Position



☐ Neutral ☐ ABduct ☐ ADduct

☐ Fixed ☐ Subluxed
☐ Partly Flexible ☐ Dislocated
☐ Flexible

Windswept

☐ Neutral ☐ Right ☐ Left

☐ Fixed ☐ Other
☐ Partly Flexible
☐ Flexible

Range of Motion

	Left	Right
Flex:	_____ o	_____ o
Ext:	_____ o	_____ o
Int R:	_____ o	_____ o
Ext R:	_____ o	_____ o

KNEES & FEET

Knee R.O.M.

Left	Right
☐ WFL	☐ WFL
☐ Flex_____ o	☐ Flex_____ o
☐ Ext _____ o	☐ Ext _____ o

Strength:

Hamstring ROM Limitations:
(Measured at ___ o Hip Flex)
Left_____ Right_____
Orthosis?
Prosthetic?

Foot Positioning

☐ WFL	☐ L	☐ R
☐ Dorsi-Flexed	☐ L	☐ R
☐ Plantar Flexed	☐ L	☐ R
☐ Inversion	☐ L	☐ R
☐ Eversion	☐ L	☐ R

Foot Positioning Needs:

MOBILITY

Balance

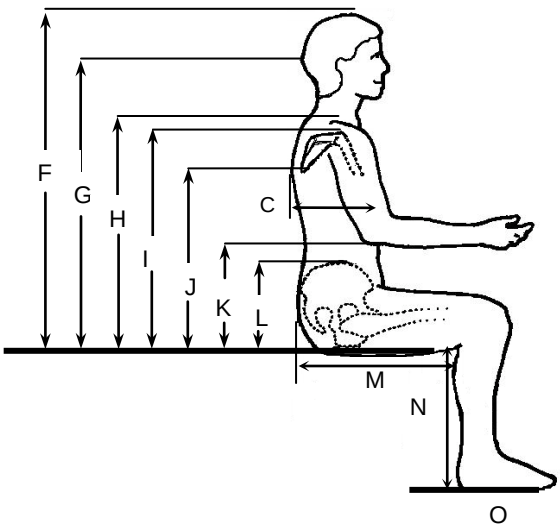
Sitting Balance:	Standing Balance
☐ WFL	☐ WFL
☐ Min Support	☐ Min Support
☐ Mod Support	☐ Mod Support
☐ Unable	☐ Unable

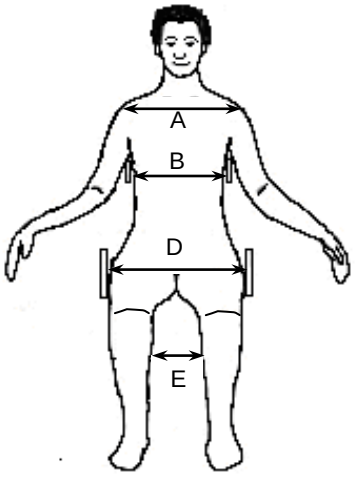
Transfers

☐ Independent
☐ Min Assist
☐ Max Asst
☐ Sliding Board
☐ Lift / Sling Required

Ambulation

☐ Unable to Ambulate
☐ Ambulates with Assistance
☐ Ambulates with Device
☐ Independent without Device
☐ 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
	E: Between Knees			**L:**	Iliac Crest
	F: Top of Head			**M:**	Sacrum to Popliteal Fossa
	G: Occiput			**N:**	Knee to Heel
				O:	Foot Length

Additional Comments and please add Trunk and Pelvic width with brace/ Orthosis, when applicable.
** Asymmetrical Width: i.e., windswept or scoliotic posture; measure widest point to widest point

REQUESTED EQUIPMENT:

Requested Frame (make and model):
Dimensions:
Amount of growth available:

SIGNATURE:

As the evaluating therapist, I hereby attest that I have personally completed this five page evaluation form and that I am not an employee of or working under contract to the manufacturer(s) or the provider(s) of the durable medical equipment recommended in my evaluation. I further attest that I have not and will not receive remunerations of any kind from the manufacturer(s) or the Medicaid Durable Medical Equipment provider(s) for the equipment I have recommended with this evaluation. I accept the responsibility of performing a follow-up evaluation at the time of the initial fitting and delivery of the recommended equipment and will be available for a follow-up evaluation six months after the equipment was delivered to recommend any additional adjustments, if a six-month follow up evaluation is needed.

I am currently enrolled as a Medicaid provider and my provider number is: _____

or, I am not currently enrolled as a Medicaid Provider and have attached a copy of my current (double click on appropriate box and select: Checked):

	License #
☐ Physical Therapy license	
☐ Occupational Therapy license	
☐ Physiatrist board certification	

_____ _____ _____

Signature, as it appears on license or certification ***Date*** ***Daytime contact number(s)***

_____ _____ _____

Fax Number ***Email Address*** ***Cell phone number (optional)***

Optional:

Physician: I have read & concur with the above assessment _____ **Date:** _____ **Phone:** _____