UPMC Presbyterian
*Center for Assistive Technology*

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# *MOBILITY ASSISTIVE EQUIPMENT*
## *CLIENT EVALUATION & IN-TAKE FORM*

**Therapy Evaluation Date:** _____
**Physician Face to Face Evaluation Date:** _____
**Home Evaluation Date:** _____
**Specifications Received from Supplier:** _____
**Date Letter Completed:** _____

**1. PRE-ASSESSMENT SCREENING:**

**NAME:**
_____

**MEDICAL RECORDNUMBER:**
_____

**ADDRESS:**
_____

**TELEPHONE NUMBER:**
_____

**DATE OF BIRTH:**
_____

**AGE:**
_____

**PRIMARY DIAGNOSES:**
_____
_____

**SECONDARY DIAGNOSES:**
_____
_____
_____

**INSURANCE #1:**

_____

**INSURANCE #2:**

_____

**REFERRAL SOURCE:**

_____

**PRIMARY CARE PHYSICIAN & ADDRESS:**

_____

_____

_____

**REASON FOR REFERRAL:**

_____

**TYPE OF CURRENT MAE:**

_____

_____

_____

**HOURS PER DAY USING CURRENT MAE:**

_____

**AGE OF MAE:**

_____

**PROBLEMS WITH CURRENT MAE:**

_____

_____

_____

**HEIGHT:**

_____

**WEIGHT:**

_____

**PREFERRED SUPPLIER:**

_____

**TRANSPORTATION RESOURCES:**

_____

_____

**LIVING SITUATION:**

_____

_____

_____

**2. THERAPY FACE TO FACE ASSESSMENT:**

**Mobility Related ADL STATUS:**

- **Bathing:** _____
- **Hygiene:** _____
- **Dressing:** _____
- **Self-Feeding:** _____

**Instrumental ADL Status:** _____ _____ _____

- **Meal Preparation:** _____
- **Housecleaning:** _____
- **Managing Finances:** _____
- **Shopping:** _____
- **Medication Management:** _____
- **Laundry:** _____
- **Care of Others:** _____

**Transfer Status:** _____

**Weight Shift:** _____

**Functional Mobility:** _____

**Community Mobility:** _____

**Cognition:** _____

**Leisure Interests:** _____

**Home Accessibility:** _____ _____ _____

**Functioning Everyday with a Wheelchair (FEW) TOOL**

**DIRECTIONS TO CLIENT:** Please tell me your level of agreement that best matches your ability to function with your current Mobility Assistive Equipment. All examples may not apply to you, and there may be tasks you perform that are not listed. (Go to www.few.pitt.edu for additional instructions if necessary as this is a self-rapport questionnaire)

6= completely agree
5= mostly agree
4= slightly agree
3= slightly disagree
2= mostly disagree
1= completely disagree
0= does not apply

| | |
|---|---|
| 1. The ***stability, durability, and dependability*** features of my wheelchair/scooter contribute to my ability to carry out my daily routines as independently, safely, and efficiently as possible | *** |
| Comments: | |
| 2. The size, fit, postural support and functional features of my wheelchair/scooter match my ***comfort needs*** | |
| Comments: | |
| 3. The size, fit, postural support and functional features of my wheelchair/scooter match my ***health needs*** | |
| Comments: | |
| 4. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***operate*** it as independently, safely, and efficiently as possible | |
| Comments: | |
| 5. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***reach*** and carry out tasks at different surface heights as independently, safely, and efficiently as possible | |
| Comments: | |
| 6. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***transfer*** from one surface to another as independently, safely, and efficiently as possible | |
| Comment: | |
| 7. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***carry out personal care tasks*** as independently, safely, and efficiently as possible | |
| Comments: | |
| 8. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***get around indoors*** as independently, safely, and efficiently as possible | |
| Comments: | |

| | |
|---|---|
| 9. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***get around outdoors*** as independently, safely, and efficiently as possible | |
| Comments: | |
| 10. The size, fit, postural support and functional features of my wheelchair/scooter allow me to ***use personal or public transportation*** as independently, safely, and efficiently as possible | |
| Comments: | |

## 3.THERAPY PHYSICAL MOTOR ASSESSMENT:

### UPPER EXTREMITY FUNCTION:

### LOWER EXTREMITY FUNCTION:

### POSTURE (SITTING & SUPINE):

## 4. GOALS FOR A NEW SEATING & MOBILITY DEVICE:

1)

2)

3)

4)

## 5. PHYSICIAN FACE TO FACE ASSESSMENT:

See Attached Physician Note

## 6. EVALUATION PROCEDURES:

**CLINICAL TRIALS/SIMULATION:**

**Pressure Mapping:**

_____
_____
_____
_____
_____

**SmartWheel:**

_____
_____
_____
_____
_____

**Other Tests:**

_____
_____
_____
_____
_____

**Devices Tried:**

_____
_____
_____
_____
_____

**Client Impressions:**

_____
_____
_____

**Home Assessment:** See supplier report/attestation.

## 7. RECOMMENDATIONS:

**Mobility Assistive Equipment:**

**Supplier:**

**Estimated Length of Need:**

| INTERVENTION & SPECIFICATION | JUSTIFICATION |
|---|---|
| **Seat** | |
| **Seat Frame or Seat Function** | |
| **Seat Frame or Seat Function** | |
| **Lap Belt** | |
| **Thigh Guides /Abductor Wedge** | |
| **Leg /Foot Support-** | |

| | |
|---|---|
| **Back Support-** | |
| **Head Support** | |
| **Arm Support-** | |
| **Tires /Casters** | |
| **Wheel-Locks /Anti-tippers** | |
| **Tie Downs** | |
| **Controller** | |
| **Batteries** | |
| **Other Feature** | |
| **Other Feature** | |

| | |
|---|---|
| **Other Feature** | |

**IMPLEMENTATION PLAN:** The specifications of this prescription will be submitted to _____ primary care physician and insurance carrier for authorization. Upon approval the specifications will be provided by _____ and delivered to the Center for Assistive Technology for fitting and delivery. Upon delivery, the client will be trained in the use of the mobility device and will demonstrate safe and effective use. In addition, he will be given information about its maintenance. Follow-up appointments will be scheduled as needed to modify the equipment as well as to verify that it continues to meet his needs.

This concludes our face to face assessment and we are all in agreement.

_____Date:_____
Therapist Signature

**Physician Comments:**
_____
_____
_____
_____
_____

_____Date:_____
Physician Signature