

Idaho Medicaid Seating and Mobility Evaluation

Fax to: 877-314-8782

Required for any wheelchair needed for longer than 3 months – please fill in completely to avoid delays.

Name:		MID:		Date of evaluation:	
Address:		Phone:		Physician:	
		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	OT:	
Other insurance:		Height:	Weight:	PT:	
Referred by:			Date referred:		
Reason for referral:					
Patient Goals:					
Caregiver Goals:					
MEDICAL HISTORY					
Primary Diagnosis:				ICD:	
Secondary Diagnosis:				ICD:	
Other Diagnoses:				ICD:	
Hx/Progression: (Symptoms)					
Recent/Planned Surgeries:					
Cardio-Respiratory: <input type="checkbox"/> Intact <input type="checkbox"/> Impaired		Comments, other DME currently used (O2, IV, etc.):			
CURRENT SEATING/MOBILITY (Type – Manufacturer – Model)					
Chair:				Age of chair:	
W/C cushion:	Age of Cushion:	W/C Back:	Age of Back:		
Reason for <input type="checkbox"/> Replacement <input type="checkbox"/> Repair <input type="checkbox"/> Update: Why is current equipment not meeting medical needs?					
Funding Source:					
HOME ENVIRONMENT					
<input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Alone					
<input type="checkbox"/> w/Family Caregivers (list):					
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					
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:					
Notes:					
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:			
Attention/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:			

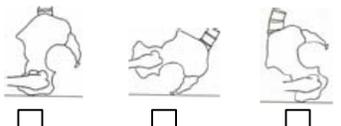
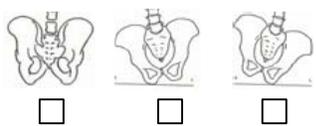
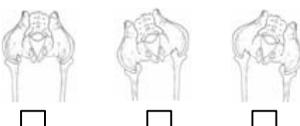
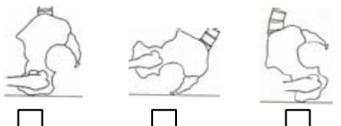
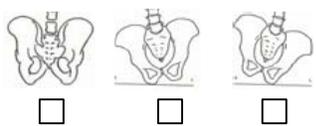
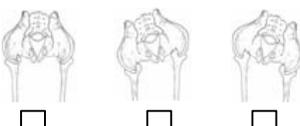
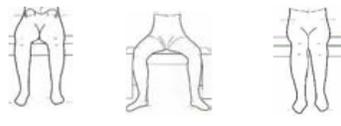
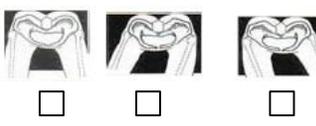
ADL STATUS				
Activity	Indep.	Assist	Unable	Comments/Other AT Equipment Required
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<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 Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Home Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
School/Work	<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:					
Skill	Indep.	Assist	Unable	NA	Comments/History of Past Use
Bed ↔ W/C transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Device: Type:
W/C ↔ Commode transfer	<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"/>	
Manual W/C propulsion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Power W/C, std. joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Power W/C, alt. controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hours spent sitting in W/C each day:				Comments:	

SENSATION:		
<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	<input type="checkbox"/> Absent
HX 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain:
Are there cognitive or sensory deficits (awareness / judgment / vision / etc) that limit the users ability to safely participate in one or more MRADL's?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain:
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 Explain:
If a POV is recommended, does the user have sufficient stability and upper extremity function to operate it?	<input type="checkbox"/> Yes <input type="checkbox"/> No 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 Explain:

RECOMMENDATION:	
<input type="checkbox"/> MANUAL WHEELCHAIR <input type="checkbox"/> POV <input type="checkbox"/> POWER WHEELCHAIR <input type="checkbox"/> SEATING <input type="checkbox"/> POSITIONING SYSTEM (SPECIFY):	
Physical / Occupational Therapist:	Signed _____ Date: _____ Phone: _____
Physician:	Signed _____ Date: _____ Phone: _____

MAT EVALUATION: (NOTE IF ASSESSED SITTING OR SUPINE)				
	POSTURE:	FUNCTION:	COMMENTS:	SUPPORT:
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		
UPPER EXTREMITY	SHOULDERS: WFL: <input type="checkbox"/> L <input type="checkbox"/> R Elev/Drop <input type="checkbox"/> L <input type="checkbox"/> R Pro/Retract <input type="checkbox"/> L <input type="checkbox"/> R Subluxed <input type="checkbox"/> L <input type="checkbox"/> R	ROM – Reach to: Overhead <input type="checkbox"/> L <input type="checkbox"/> R Shoulder Ht. <input type="checkbox"/> L <input type="checkbox"/> R Wheel Ht. <input type="checkbox"/> L <input type="checkbox"/> R STRENGTH:		
	ELBOWS: Impaired: <input type="checkbox"/> L <input type="checkbox"/> R WFL: <input type="checkbox"/> L <input type="checkbox"/> R	ROM: STRENGTH:		
WRIST/HAND	Impaired: <input type="checkbox"/> L <input type="checkbox"/> R WFL: <input type="checkbox"/> L <input type="checkbox"/> R	STRENGTH/DEXTERITY:		
TRUNK	ANTERIOR/POSTERIOR  <input type="checkbox"/> WFL <input type="checkbox"/> Thoracic Kyphosis <input type="checkbox"/> Lumbar Lordosis <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	LEFT/RIGHT  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right <i>Views above are posterior</i> <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	ROTATION  <input type="checkbox"/> Neutral <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	
	ANTERIOR/POSTERIOR  <input type="checkbox"/> WFL <input type="checkbox"/> Posterior Tilt <input type="checkbox"/> Anterior Tilt <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	OBLIQUITY  <input type="checkbox"/> WFL <input type="checkbox"/> L Lower <input type="checkbox"/> R Lower <i>Views above are posterior</i> <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	ROTATION  <input type="checkbox"/> WFL <input type="checkbox"/> Right <input type="checkbox"/> Left <i>Views above are anterior</i> <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	
PELVIS	ANTERIOR/POSTERIOR  <input type="checkbox"/> WFL <input type="checkbox"/> Posterior Tilt <input type="checkbox"/> Anterior Tilt <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	OBLIQUITY  <input type="checkbox"/> WFL <input type="checkbox"/> L Lower <input type="checkbox"/> R Lower <i>Views above are posterior</i> <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	ROTATION  <input type="checkbox"/> WFL <input type="checkbox"/> Right <input type="checkbox"/> Left <i>Views above are anterior</i> <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	
HIPS	POSITION  <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	WINDSWEPT  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <i>Views above are posterior</i> <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Fixed <input type="checkbox"/> Other	RANGE OF MOTION L: Flex _____° Ext _____° Int R _____° Ext R _____° R: Flex _____° Ext _____° Int R _____° Ext R _____°	Lower Extremity-able to: <input type="checkbox"/> Bear weight <input type="checkbox"/> Sit to stand <input type="checkbox"/> Floor sit to stand

MAT EVALUATION, CONTINUED: (NOTE IF ASSESSED SITTING OR SUPINE)

KNEE & FEET	KNEE RANGE OF MOTION	Strength:	FOOT POSITIONING	Foot positioning needs:
	L: <input type="checkbox"/> WFL Flex _____° Ext _____° R: <input type="checkbox"/> WFL Flex _____° Ext _____°	Knee extension ROM @ _____ degrees of hip flex L: _____ R: _____	<input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Dorsi-flexed <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Plantar flexed <input type="checkbox"/> L <input type="checkbox"/> R <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	Notes:
	WFL <input type="checkbox"/> Sit: <input type="checkbox"/> Stand: <input type="checkbox"/> Min Support <input type="checkbox"/> <input type="checkbox"/> Mod Support <input type="checkbox"/> <input type="checkbox"/> Unable <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Independent <input type="checkbox"/> Minimal Assistance <input type="checkbox"/> Maximal Assistance <input type="checkbox"/> Sliding Board <input type="checkbox"/> Lift/Sling Required <input type="checkbox"/> Floor to Chair	<input type="checkbox"/> Unable <input type="checkbox"/> With assistance <input type="checkbox"/> With device <input type="checkbox"/> Indep. w/o device <input type="checkbox"/> Indep. short dist. only	

NEUROMUSCULAR STATUS:

Tone:

Reflexive Responses:

Effect on Function:

MEASUREMENTS – 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 - <i>for asymmetrical width (scoliotic or windswept) measure widest pt. to widest pt.</i>			J: Inferior Angle of Scapula
E: Between Knees			K: Iliac Crest
F: Top of Head			M: Sacrum to Popliteal Fossa
G: Occiput			N: Knee to Heel
			O: Foot Length

Summary of Postural Asymmetries:
Additional Comments:

Physical / Occupational Therapist:	Signed	Date:	Phone:
Physician:	Signed	Date:	Phone:

Please submit to fax number listed at top with accompanying DME request form and letter of medical necessity. See www.dme.idaho.gov for instructions, DME forms and more information.