Patient's Name ____

Alabama Medicaid Agency
WHEELCHAIR / SEATING EVALUATION

This form is a required attachment to the Alabama Medicaid Prior Review and Authorization Form (Form 342). It must be completed by an Alabama licensed Physical Therapist (PT)/Occupational Therapist (OT). Alabama Medicaid will only reimburse for the physical therapy evaluation for wheelchairs (manual with accessories and all power wheelchairs) for adults if the PT/OT is employed by a hospital enrolled with Alabama Medicaid and the evaluation must be performed in the hospital outpatient setting.

Disclaimer: Alabama Medicaid Agency or its designee may request additional information to support the appropriateness of this request, including, but not limited to, a trial of the requested wheelchair to determine the recipient's ability to independently operate the wheelchair. If a wheelchair is unavailable for a trial, documentation must be submitted to justify the request.

Start Time __________________ End Time __________________ Today's Date __________________

Referral Information
Are you receiving services of any kind (therapy, nursing, school etc.)? ____
Physician _________________________________ Phone ___________________ Fax __________________

Case Manager / VR/IL counselor _______________________________________ Phone _____________________
Reason for Referral ____

Patient Information Age __________ Date of Birth_________________
Person accompanying patient ___________________________ Employment/School _________________________
Other Daily Activities ____
Handedness □ Right □ Left □ N/A Comments ____
Diagnosis/Medical/Surgical History ____
____

Height __________ Weight __________ Recent wt □ gain □ loss _____________________________________
Vision __________________________________ Cognition ____

Current Wheelchair / Seating System
□ None □ Dependent □ Manual Tilt in Space □ Manual □ Scooter □ Power
Manufacturer _________________________________ Model __________________ Serial # __________________
Age of chair ______________________ Provider __________________ Funding ________________
Frame width ____________ Frame depth ___________ Overall width ___________ Overall length ____________
Cushion style ________________________ Age ____________ Back Type_______________________ Age ________
Back height ___________ Front seat to floor height _________ Rear seat to floor height _________
Power: Drive Control Type ____
Other seating components? ____
____
Problems with chair? ____
Goals for new WC/Equipment ____
____
□ Modifiable □ Requires Replacement Comments ____
# of hours spent in current WC ______________ Goal for time to be up in WC: _________________
Other DME owned? ____

Home Environment Lives with ____ # Levels to home _____________
□ House □ Apartment □ Condo/Townhome □ Mobile Home □ Asst Living □ LTCF □ Group Home
□ Rural □ Urban **Ramps** □ Yes □ No **Sidewalks** □ Yes □ No **Paved driveway** □ Yes □ No
Terrain □ flat □ rough □ hills □ grass □ gravel □ carpet □ other: ___________________________________
Entrance stairs □ Yes □ No Number __________ Rails? ______
Accessibility issues ____
Accommodation Plans ____

Caretaker Primary Caregiver ____
Patient spends time at home alone □ Yes □ No Hours alone ___________
Patient has homecare assistance or personal care attendant? □ Yes □ No
Caretaker limitations ____+________

Therapist Signature/Date ____________________________________

Patient's Name ____

WHEELCHAIR / SEATING EVALUATION

Transportation Does patient drive? □ Yes □ No Need Driver's Eval? ____________________________
□ Car □ Van □ Public Transportation/Bus □ Ambulance □ Truck □ SUV □ Other __________________
□ Sits in WC during transport □ Yes □ No Where does WC go in the vehicle? ________________________________
Security Type □ Tie downs □ EZ Lock Does current WC fit in Van lift opening? ____________________________
Future Transportation Plans ____________________________ Need info on Lifts/Ramps? _______________________

Communication Verbal □ WFL □ Difficult to understand □ Non-communicative
□ Uses an augmentative communication device Manufacturer/Model _______________________________________
AAC mount needed ________ Comments ____

Pain (location/ pain scale) UEs? _____________________________ Back? ___________________________________
Other ____
Comments ____

Skin Condition/Integrity
□ Independent for pressure relief □ Needs Assistance for pressure relief □ Unable to self position
Method of pressure relief ______________________________________ Frequency ___________________________
Sensation □ Intact □ Impaired □ Absent Level of sensation ________________________________
Skin breakdown present □ Yes □ No Description/Comments ____
PMH of pressure ulcer □ Yes □ No Description/Comments ____
Other risk factors Check all that apply □ bony prominences □ impaired nutritional status
□ impaired circulation □ fecal incontinence □ urinary incontinence □ smoking □ Yes □ No
Bowel Function □ Continent □ Incontinent □ Accidents - How Managed _____________________________
Bladder Function □ Continent □ Incontinent □ Accidents - How Managed _____________________________
Comments ____
____

ADL Status (in reference to wheelchair use) Per Report of Patient or caregiver

	Indep	**Assist**	**Unable**	**Indep W/ Equip**	**Comments**
Dressing					
Eating					
Grooming/Hygiene					
Meal Prep					
Bathing					
Toileting					
Bed Mobility					
IADLs (laundry, shopping, etc…)					

Current Mobility Status:
□ Gait Distance ______ Device _______ Bracing _______ Assist _______ Gait Speed (m/s) ______
Deviations ____ Timed Up and Go Test ____________________
□ Unable to ambulate Comments ____
□ History of falls? ____

Manual Wheelchair Mobility Method of propulsion ____
Is the patient able to propel any type of manual WC even when well configured? _________________________________
If no, explain ____
____

Power Wheelchair Mobility:
Does the patient demonstrate the ability to independently (age appropriate independence) drive the PWC/POV safely?
Yes No Explain/describe trial if applicable ____
____

Therapist Signature/Date ____________________________________

Patient's Name ____________________

WHEELCHAIR / SEATING EVALUATION

Supine Evaluation			Fixed	Flexible	Comments
__ Pelvic tilt:	□ ant.	□ post.	□	□	____________________
__ Pelvic obliquity:	□ left	□ right	□	□	____________________
__ Pelvic rotation:	□ left	□ right	□	□	____________________
__ Thoracic Kyphosis:			□	□	____________________
__ Lordosis:	□ inc.	□ dec.	□	□	____________________
__ Scoliosis:	□ left	□ right	□	□	____________________

Sitting Evaluation			Fixed	Flexible	Comments
__ Pelvic tilt:	□ ant.	□ post.	□	□	____________________
__ Pelvic obliquity:	□ left	□ right	□	□	____________________
__ Pelvic rotation:	□ left	□ right	□	□	____________________
__ Kyphosis:			□	□	____________________
__ Lordosis:	□ inc.	□ dec.	□	□	____________________
__ Scoliosis:	□ left	□ right	□	□	____________________
__ Head: tilt	□ left	□ right	□	□	____________________
__ Head: rotation	□ left	□ right	□	□	____________________
__ Head:	□ ext	□ flex □ forward	□	□	____________________
__ Cervical hyperextension			□	□	____________________
__ LE abduction:	□ left	□ right	□	□	____________________
__ LE adduction:	□ left	□ right		□	____________________
__ UE position: ____________			□	□	____________________
__ Windswept	□ left	□ right			

Describe Movement Patterns: ____

____

Key Muscles	Range of Motion		Strength		Muscle Tone		Comments
	Left	Right	Left	Right	Left	Right	
Shoulder flexion							
Shoulder abduction							
Shoulder ER							
Elbow flexion							
Elbow extension							
Wrist flexion							
Wrist extension							
Hand Grip (Dynamometer if possible)							
Hip flexion							
Knee flexion							
Knee extension							
Dorsiflexion							
Plantarflexion							
Knee ext./In Sitting							

Postural Tendency □ Anterior □ Posterior Insitting □ Left Lateral □ Right Lateral	Head Control □ Good □ Adequate □ Limited □ Absent
Foot Position (Note Fixed or Flexible)	Edema

Therapist Signature/Date ____________________

Patient's Name ____

WHEELCHAIR / SEATING EVALUATION

Balance		Transfers
Sitting balance	**Standing balance**	□ Method:
□ WFL - static and dynamic	□ WFL	□ Device
□ Uses UE for balance in sitting	□ Minimal assistance	□ Independent
□ Minimal assistance	□ Moderate assistance	□ Supervision
□ Moderate assistance	□ Maximum assistance	□ _________________ assist
□ Maximum assistance	□ Unable	
□ Unable	□ Device Needed	
Time standing before Fatigue/Pain		Functional Reach

Measurements in inches (taken in optimal position for fit of seating equipment)

Head Height _____________ Hip Width ____________ Footwear __________________

Shoulder Height R ______ L ______ Depth ____________

Inf Scapular Height R ______ L ______ Thigh Depth R ______ L ______

Elbow Height R ______ L ______ Lower Leg length R ______ L ______

Forearm Depth R ______ L ______ Chest Width ______

Shoulder Width ______ Trunk Depth ______

Widest Point ______ External Knee Width ______

Other ____

Assessment/Trial of equipment:

NOTE: A trial of equipment is highly recommended especially if this is new equipment or a change in equipment (i.e., MWC to PWC), recommendation of PWC for a child or someone with cognitive impairments of any level. It is also highly recommended that a home assessment and/or trial be completed by vendor &/or therapist to ensure the recommended equipment will meet the goals and the home is accessible.

(Chairs/Cushions/Backs) ____

____

Pressure mapping performed □Yes □ No Results ____

____

Outpatient follow up required: □ Yes □ No Education provided on various options? □ Yes □ No

Photos taken? □ Yes □ No (Note: if yes, include consent form)

Patient and/or caregiver in agreement with recommendations? □ Yes □ No **Goals of Mobility (Check all that apply)**

□ The patient and/or caregiver actively participate in appointment for fitting and training with recommended equipment.

□ The patient and/or caregiver will demonstrate adequate knowledge of safe and functional operation, use and care of the recommended equipment.

□ Meet caregiver goals (**specify**____)

□ Meet transportation/vocational/school needs (**specify** ____)

□ Provide independent in mobility in the home and motor related ADLs (MRADLs) in the community, **such as**

____

□ Allow patient to be independent with ADLs **such as** ____

□ Provide dependent mobility.

□ Patient to be independent with pressure reliefs in the wheelchair.

□ Provide wheelchair base that includes tilt. List goals for tilt ____________________________________

□ Provide wheelchair base that includes recline.

List goals for recline ____

Goals for seating system for client

□ Optimize pressure distribution to assist in the prevention of decubitus ulcers

□ Provide corrective forces to assist with maintaining or improving posture (**specify** ______________________)

□ Accommodate and support client's posture: current seated postures and positions are not flexible or will not tolerate corrective forces. (**specify** ____)

□ Enhance physiological function such as breathing, swallowing, digestion.

□ Reduce pain in the sitting position.

□ **Other Goals**

Therapist Signature/Date ____________________________________

Patient's Name ____________________________________

WHEELCHAIR / SEATING EVALUATION

Recommendations	Equipment	Justification
Mobility Base		
Electronics/ Method of Driving Power Wheel Chair		
Power Seat Functions		
Color		
Seat width		
Seat Depth		
Seat Frame height	Front _________ Rear___________	
Back Support height		
Back Support		
Lateral Trunk supports		
Armrest Support Type		
Additional Arm support Type		
Drive Wheels/Tires		
Caster Type/Size		
Handrim		
Lower leg assembly		
Lower leg/Ankle/Foot Support		
Foot plate type		

Therapist Signature/Date ___________________________________

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Seat type (solid pan, upholstery, solid seat insert)		
Seat Cushion		
Lateral pelvic/Hip guides		
Lateral Knee support		
Medial Knee support		
Pelvic Positioning Belt		
Lap Tray		
Head Support		
Batteries Size		
Anti-tip device		
Push handles		
Wheel Locks		
Clothing guards		
Anterior Chest support		
Other		

Referrals ____

Education/Information Provided ____

____

I have no financial relationship with the supplier of equipment.

Therapist Signature/Date ___________________________________

Patient's Name ____

WHEELCHAIR / SEATING EVALUATION

Comments: (Use this space to further describe patient's medical condition or change in medical/functional status, objective reasons for growth of seating system, detail or trial in new mobility equipment or any other information to thoroughly justify recommended equipment).

Please fill in all appropriate blanks to provide a thorough evaluation. **If a section on the form is not applicable (NA) for the recipient/patient, "NA" will be acceptable in that section.** ATP signature below denotes involvement in appropriate areas of this evaluation.

Therapist Signature/Date ______________________________

Telephone ____

ATP name/Date _____________________________________

ATP telephone ______________________________________

Vendor Name/NPI ___________________________________