



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: _____
Funding: _____	Age: _____ Sex: _____	OT: _____
Referred By: _____	Date of Birth: _____	PT: _____
	Height: _____	Soc. Sec. No: _____
	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: _____	Comments: _____	
<input type="checkbox"/> Intact <input type="checkbox"/> Impaired		

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

Chair: _____	Age: _____
Serial # _____	
w/c Cushion: _____	Age: _____
w/c Back: _____	Age: _____
Other Positioning Components: _____	
Reason for <input type="checkbox"/> Replacement / <input type="checkbox"/> Repair / <input type="checkbox"/> Update: _____	
Funding Source: _____	

HOME ENVIRONMENT:

<input type="checkbox"/> House <input type="checkbox"/> Apt <input type="checkbox"/> Asst Living <input type="checkbox"/> LTCF <input type="checkbox"/> Alone <input type="checkbox"/> w/ Family-Caregivers:	
Length of time at residence: _____	
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: _____
Is a caregiver available 24 hours a day: <input type="checkbox"/> Yes <input type="checkbox"/> 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	<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:
Attn / 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: 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 Prep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Home Management	<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: Indep Assist Unable N/A Comments

Bed ↔ w/c Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
w/c ↔ Commode Transfers	<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"/>	Device:
Manual w/c Propulsion:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Operate Power w/c w/ Alternative Controls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ability to Stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Able to Perform Weight Shifts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type:
Hours Spent Sitting in w/c Each Day:					Comments:

SENSATION:

<input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent	Hx of Pressure Sores <input type="checkbox"/> Yes <input type="checkbox"/> No
Current Pressure Sores <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 supprt 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 <input type="checkbox"/> 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: _____

Please Note: Clinical documentation of a power wheelchair trial must accompany any first request for a power wheelchair

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	<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 <input type="checkbox"/> Tone/ Reflex		
U P P E R E X T R E M I T Y	SHOULDERS Left Right <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> elev / dep <input type="checkbox"/> elev / dep <input type="checkbox"/> pro / retract <input type="checkbox"/> pro / retract <input type="checkbox"/> subluxed <input type="checkbox"/> subluxed	R.O.M. Strength: Tone/Reflex:		
	ELBOWS Left Right <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	R.O.M. Strength: Tone/Reflex:		
W R I S T & H A N D	Left Right <input type="checkbox"/> Impaired <input type="checkbox"/> Impaired <input type="checkbox"/> WFL <input type="checkbox"/> WFL	Strength / Dexterity:		
T R U N K	Anterior / Posterior  <input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic Kyphosis <input type="checkbox"/> ↑ Lumbar Lordosis <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	Left Right  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	Rotation  <input type="checkbox"/> Neutral <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other	