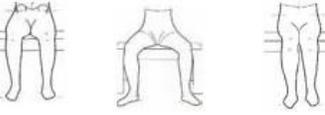


Idaho Medicaid Seating and Mobility Evaluation

Fax to the Medical Care Unit **With** the Idaho Medicaid DME Request Form and all supporting documentation
Required for any wheelchair needed for longer than 3 months (except K0001) – please fill in completely to avoid delays
If additional room is need for required comments or notes please use a separate piece of paper

PARTICIPANT INFORMATION			
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 – Manufacture – 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, Caregiver (list facility or with whom):			
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:	
Judgement	<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 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"/>	
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"/>	
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 user's 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:	
How many total hours per day does the participant sit or expect to sit in the wheelchair?					
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):			

MAT EVALUTATION: (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 Hypertension	<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 EXTRE-MITY	<i>SHOULDERS:</i> 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:		
	<i>ELBOWS:</i> Impaired WFL <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R	ROM: STRENGTH:		
WRIST/ HAND	Impaired: WFL <input type="checkbox"/> L <input type="checkbox"/> R <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 <i>Views above are anterior</i> <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	
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	WINDSWEEP  <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 EVALUTATION, CONTINUED: (NOTE IF ASSESSED SITTING OR SUPINE)

KNEE & FEET	KNEE RANGE OF MOTION L: <input type="checkbox"/> WFL Flex _____ ° Ext _____ ° R: <input type="checkbox"/> WFL Flex _____ ° Ext _____ °	Strength: Knee extension ROM @ _____ ° of hip flex L: _____ R: _____	FOOT POSITIONING <input type="checkbox"/> WFL <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Dorsi- <input type="checkbox"/> L <input type="checkbox"/> R flexed <input type="checkbox"/> Plantar <input type="checkbox"/> L <input type="checkbox"/> R Flexed <input type="checkbox"/> Inversion <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> Eversion <input type="checkbox"/> L <input type="checkbox"/> R	Foot Positioning Needs:
------------------------	---	--	---	-------------------------

MOBILITY	BALANCE Sit: Stand: WFL <input type="checkbox"/> <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"/>	TRANSFERS <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	AMBULATION <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	Notes:
-----------------	---	---	--	--------

		<p>NEUROMUSCULAR STATUS:</p> <p>Tone:</p> <p>Reflexive Responses:</p> <p>Effect on Function:</p>
--	--	---

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 – for asymmetrical width (scoliotic or windswept) measure widest pt. to widest pt.			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 with accompanying DME request form and letter of medical necessity.
See www.dme.idaho.gov for instructions, DME forms and more information.