

Seating & Mobility Evaluation

Patient Information:

Name: _____	Date of Evaluation: _____	Physician: _____
Address: _____	Sex: _____ Age: _____	Therapist: _____
_____	Height: _____ Weight: _____	Therapist: _____
Phone: _____	Primary Caregiver: _____	Supplier: _____
Email: _____	Caregiver Phone: _____	Company: _____
Funding Source: _____	Referred By: _____	Supplier Phone: _____

Reason for Referral: _____

Patient Goals: _____

Caregiver Goals: _____

Medical History:

Dx: _____

Other related Diagnoses: _____

Hx: _____

Recent/Planned Surgeries: _____

Cardio-Respiratory Status: _____

Impaired: Yes No

Medications: _____

Current Seating/Mobility:

Chair: _____ Age: _____ Serial Number: _____ W/C Cushion: _____ Age _____ W/C Back: _____ Age: _____

Reason for: Replacement Repair Update Comments: _____

Additional Equipment used on chair:

Replace with O2/Ventilator _____ Age: _____ Stander: _____ Age: _____

Bath Equipment: _____ Age: _____ Augmentive Com Device: _____

Mounting: _____ Comments: _____

Home Environment:

House Apt Asst Living Long Term Care Facility (LTCF)/Nursing Home Alone w/ Family-Caregivers

Entrance; Level Ramp Lift Stairs

w/c Accessible Rooms: Yes No Narrowest Doorway to Access: _____

Any Notable Critical Dimensions: _____ Comments: _____

Community Activities of Daily Living (ADL):

Transportation: Car Van Bus Adapted Van/independent driven Ambulance Other: _____

Driving Requirements: _____

Employment Requirements: _____

Educational Requirements: _____

Terrain Encountered: _____

Typical Distance: _____

Other: _____

Cognitive / Visual / Hearing 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 _____
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 _____
Communication:	<input type="checkbox"/> Intact	<input type="checkbox"/> Impaired	Comments _____

Ambulation:

Unable With Device

Distance: _____

Falls: _____

Other Safety Issues: _____

Seating & Mobility Evaluation *(Continued)*

Muscle Tone:

Normal
 Low Tone Describe: _____
 High Tone Describe: _____
 Dystonic Describe: _____
 Abnormal Reflexes Describe: _____
 Medical Management: _____

ADL Status:

	Indep	Assist	Unable	Comments:
Dressing/Bathing: Feeding:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grooming/Hygiene:	<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"/>	_____
Bladder/Bowel Management:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
	<input type="checkbox"/> Continent		<input type="checkbox"/> Incontinent	

Wheelchair Management:

	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"/>	_____
Manual W/C Propulsion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Operate Power W/C Std. Joystick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Operate Power W/C Alt. Controls	<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"/>	_____
Bed Confined without W/C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Activity Level: _____					
Additional Comments: _____					

Sensation:

Intact Impaired Absent Hx of Pressure Injuries Yes No Current Pressure Injuries Yes No Waterlow Score _____
 Comments: _____



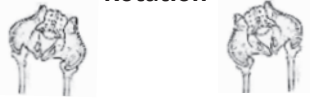



Mode of Weight Shift:

Mode of Weight Shift Method: Independent Dependent Assisted
 Describe Effectiveness: _____
 Describe Duration: _____
 Describe Frequency: _____

Cognition:

Judgement: _____
 Attn / Concentration: _____
 Vision: _____







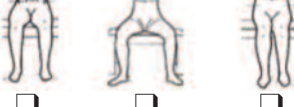


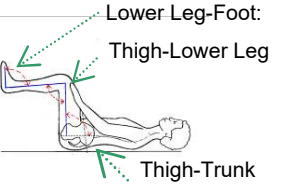
Posture in Current Seating:

PELVIS	Tilt  <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior	Obliquity  <input type="checkbox"/> Left Low <input type="checkbox"/> Right Low	Rotation  <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward
	Anterior/Posterior  <input type="checkbox"/> Kyphosis <input type="checkbox"/> Lordosis	Left Right  <input type="checkbox"/> Left Scoliosis <input type="checkbox"/> Right Sciliosis	Rotation  <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward





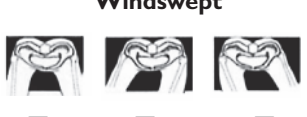




Goals:

Seating System Mobility Base Other: _____
 Comments: _____

Supine Mat Evaluation

				COMMENTS								
PELVIS With Functional Limits (WFL)	Anterior/Posterior  <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Obliquity  <input type="checkbox"/> WFL <input type="checkbox"/> Left Low <input type="checkbox"/> Right Low <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Rotation  <input type="checkbox"/> WFL <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other									
	Anterior/Posterior  <input type="checkbox"/> WFL <input type="checkbox"/> Thoracic Kyphosis <input type="checkbox"/> Lumbar Lordosis <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Left Right  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Rotation  <input type="checkbox"/> Neutral <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other									
HIPS	Position  <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct <input type="checkbox"/> Non-reducible <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Dislocated <input type="checkbox"/> Reducible	Windswept  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Non-reducible <input type="checkbox"/> Other <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Reducible	Rotation  <input type="checkbox"/> Int Rot.: _____° <input type="checkbox"/> _____° <input type="checkbox"/> Ext Rot.: _____° <input type="checkbox"/> _____°									
	Angles	Range of Motion <table border="1"> <thead> <tr> <th>Left</th> <th>Right</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Left	Right								
	Left	Right										
Trunk-Thigh Angle: "Hip flexion"												
Thigh-Low Leg Angle: "Knee Extension"												
Lower Leg-Foot Angle:												
KNEES & FEET	Foot Positioning <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	COMMENTS										
HEAD & NECK	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated <input type="checkbox"/> Lat 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	COMMENTS									

Sitting Mat Evaluation

Sitting Mat Evaluation				COMMENTS
PELVIS With Functional Limits (WFL)	Anterior/Posterior  <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Obliquity  <input type="checkbox"/> WFL <input type="checkbox"/> Left Low <input type="checkbox"/> Right Low <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Rotation  <input type="checkbox"/> WFL <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	
	HIPS	Position  <input type="checkbox"/> Neutral <input type="checkbox"/> ABduct <input type="checkbox"/> ADduct <input type="checkbox"/> Non-reducible <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Dislocated <input type="checkbox"/> Reducible	Windswept  <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Non-reducible <input type="checkbox"/> Other <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Reducible	Range of Motion  Left Right <input type="checkbox"/> Redu: _____° <input type="checkbox"/> _____° <input type="checkbox"/> Ext: _____° <input type="checkbox"/> _____° <input type="checkbox"/> Int Rot.: _____° <input type="checkbox"/> _____° <input type="checkbox"/> Ext Rot.: _____° <input type="checkbox"/> _____°
TRUNK	Anterior/Posterior  <input type="checkbox"/> WFL <input type="checkbox"/> Thoracic Kyphosis <input type="checkbox"/> Lumbar Lordosis <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Left Right  <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right Scoliosis Scoliosis <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	Rotation  <input type="checkbox"/> Neutral <input type="checkbox"/> Left Forward <input type="checkbox"/> Right Forward <input type="checkbox"/> Non-reducible <input type="checkbox"/> Reducible <input type="checkbox"/> Partly Reducible <input type="checkbox"/> Other	
	UPPER EXTREMITY	SHOULDERS Left Right <input type="checkbox"/> Functional <input type="checkbox"/> Functional <input type="checkbox"/> protracted <input type="checkbox"/> protracted <input type="checkbox"/> retracted <input type="checkbox"/> retracted <input type="checkbox"/> elevated <input type="checkbox"/> elevated <input type="checkbox"/> depressed <input type="checkbox"/> depressed <input type="checkbox"/> subluxed <input type="checkbox"/> subluxed	Significant R.O.M. Issues	COMMENTS
ELBOWS Left Right <input type="checkbox"/> Flexed <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Extended		Wrist Left Wrist Right Description:		
HEAD & NECK	<input type="checkbox"/> Functional <input type="checkbox"/> Flexed <input type="checkbox"/> Extended <input type="checkbox"/> Rotated <input type="checkbox"/> Lat 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 R.O.M.		
MOBILITY	Balance Sitting Balance Standing Balance <input type="checkbox"/> WFL <input type="checkbox"/> WFL <input type="checkbox"/> Min Support <input type="checkbox"/> Min Support <input type="checkbox"/> Mod Support <input type="checkbox"/> Mod Support <input type="checkbox"/> Unable <input type="checkbox"/> Unable	Transfers <input type="checkbox"/> Independent <input type="checkbox"/> Min Assist <input type="checkbox"/> Max Assist <input type="checkbox"/> Sliding Board <input type="checkbox"/> Hoist Required		

Seating & Mobility Evaluation *(Continued)*

RECOMMENDATIONS:

Mobility Base & Components	Justification
Seating System & Components	Justification

Sunrise Physiotherapist / Occupational Therapist Signature: _____ Date: _____

Treating Therapist: I have read and concur with the above assessment. _____