POWER MOBILITY DEVICES (PMDs) AND CUSTOM MANUAL WHEELCHAIRS

MEDICAL NECESSITY EVALUATION (completed by PT, OT, or Physiatrist)

Patients Name_____Birth Date_____/_____/_____

Diagnosis_____

Sex_____Height_____Weight_____Date of Onset_____/_____/_____ [ ] Improving [ ] Worsening

I. Brief Medical History Including Complicating Medical Conditions:

_____

_____

_____

II. Current Function:

Ambulation: [ ] None [ ] Limited/Distance:_____[ ] Assisted

[ ] Needs wheelchair for mobility Transfer Method:_____[ ] Assisted

Daily Activities Ability: **(MRADLs = mobility-related activities of daily living.)**_____

_____

_____[ ] Assisted

A [ ]Manual [ ]Power ***Superstand wheelchair*** will significantly improve patient's ability to perform MRADLs in the home.

***** Patient will use the Standing wheelchair approximately _____ hours every day inside and outside the home.

III. Physical/Medical Condition:

Arms: LEFT - [ ] Normal Strength [ ] Reduced [ ] Reduced ROM ROM_____%

[ ] Spasticity [ ] Contractures

RIGHT -[ ] Normal Strength [ ] Reduced [ ] Reduced ROM ROM_____%

[ ] Spasticity [ ] Contractures

Legs: [ ] Normal Strength [ ] Reduced [ ] None ROM_____%

[ ] Spasticity [ ] Contractures

Skin Integrity: [ ] Intact [ ] Red Area [ ] Open Area [ ] Scar Tissue [ ] History of sores

Area: [ ] Ischial Tuberosities [ ] Coccyx [ ] Spine [ ] Other_____

Bladder: [ ] Continent [ ] Incontinent [ ] Urinary Tract Infections - ____Frequent ____Infrequent

Sitting Balance: [ ] Good – hands/arms capable to shift weight [ ] Fair – hands/arms free only

[ ] Poor – propped and hands/arms needs support [ ] Dependent – needs external support

Cardiovascular: [ ] Intact [ ] Impaired [ ] Severely Impaired [ ] Limitations [ ] NA

Respiratory: [ ] Intact [ ] Impaired [ ] Severely Impaired [ ] Limitations [ ] NA

IV.

Current Mobility: [ ] Manual [ ] Power When Obtained_____/_____/_____

Condition of Wheelchair_____

Current Mobility: [ ] Does not meet patients needs [ ] Cannot be repaired to meet the patients needs

Current standing program: ____Xs a day _____Xs a week [ ] Assisted

[X] The patients condition is such that without the use of a wheelchair the patient would be bed or chair confined and:

[ ] The patient's condition is such that a manual standing wheelchair is medically necessary.
[ ] The patient's condition is such that a power standing wheelchair is medically necessary, patient is unable to operate a manual wheelchair.
[ ] The patient is mentally and physically able to operate the ordered equipment safely and responsibly.
[ ] The patient has a caregiver who will operate equipment safely and responsibly
[ ] Requested wheelchair cannot be replaced/downcoded to alternative equipment ***without standing feature.***

A fitted cane/walker or a scooter cannot be used safely or sufficiently instead of a standing wheelchair because:

_____

_____

Duration of expected wheelchair use [ ] Lifetime [ ] Other_____

Transportation: [ ] Car [ ] Van [ ] Public Transportation [ ] Other

Homestead: [ ] Wheelchair accessible [ ] Lives Alone [ ] Lives w/Others [ ] Stores Wheelchair

V. Equipment Trial:

[ ] Superstand Manual Model SS-1 [ ] Superstand _ Power Model HPS-2 [ ] Superstand Full Power Model PS-2

[ ] Superstand Bariatric Model BRSS-1 [ ] Superstand Nano (pediatric) Model

During the Superstand wheelchair trial these observations were noted:

[ ] ↑ Stretching [ ] ↑ ROM [ ] ↑ Respiratory [ ] ↓ Spasticity [ ] Good Weight Bearing Tolerance [ ] ↑ Psychological Attitude

Recommended Wheelchair:_____

VI. Goals for Superstand wheelchair equipped with sit-to-stand mechanism:

Improve circulation, reduce swelling in lower extremities	[ ] yes [ ] no
Provide pressure relief (independently), prevent decubitus ulcers	[ ] yes [ ] no
Help maintain and improve bone integrity	[ ] yes [ ] no
Improve bowel and urinary function and regularity	[ ] yes [ ] no
Improve range of motion and strengthen U/E and L/E and trunk	[ ] yes [ ] no
Prevent/reduce muscle spasms and contractures	[ ] yes [ ] no
Strengthen cardiovascular, enhance breathing, swallowing, digestion	[ ] yes [ ] no
Allow more daily living independence, improve quality of life	[ ] yes [ ] no

I the undersigned certify that the above information is true, that this patient requires the ordered equipment/accessories due to his/her medical condition(s), that the use of the equipment is not for the patient's convenience but is medically necessary for mobility and overall health. I have reviewed all information provided by the ordering physician and concur with or have noted my disagreements with their findings.

PT/OT, Physiatrist Signature Date