Technology Assessment for Seating and Wheeled Mobility

Patient Name: ____ **Date of Assessment**: _______________

Primary Diagnosis: ____

Subjective Complaint: ____

____

EXISTING EQUIPMENT (check all that the individual uses in a typical day)**:**

☐ Cane ☐ Walker ☐ Rollator ☐ Other ambulation aid ______________________________
☐ Stroller ☐ Transport wheel chair ☐ Manual wheel chair ☐ Tilt-in-space ☐ Recliner
☐ Scooter ☐ Power wheelchair ☐ Other wheeled mobility ______________________________

Primary Device:

Manufacturer: ______________________ Model name: _________________________ Size: ______________

Purchased by: ______________________ Age: _____ Condition: ____________________________________

Secondary Device:

Manufacturer: ______________________ Model name: _________________________ Size: ______________

Purchased by: _____________________ Age: _____ Condition: _____________________________________

Wheelchair Cushion / Seat Support:

Manufacturer: ______________________ Model name: ________________________ Size: ______________

Purchased by: _____________________ Age: _____ Condition: _____________________________________

Wheelchair Back / Back Support:

Manufacturer: ______________________ Model name: ________________________ Size: ______________

Purchased by: _____________________ Age: _____ Condition: _____________________________________

REASON FOR NEW EQUIPMENT (Check all reasons that apply and explain):

☐ No current device but change in functional / medical needs now requires one. *Explain*:_________________

____

____

☐ Current device no longer meets functional, medical or size needs. *Explain*:____________________________

____

____

Describe any changes that could be made to allow current device to meet client's needs: ___________________

____

☐ Current device is no longer functioning and cannot be repaired. *Specify why it cannot be repaired*: _________

____

____

☐ Cost to repair current device is greater than replacement. See attached cost-analysis of parts and labor.

Anticipated length of need: __________________________

Copyright © September 2015 Laura Cohen PhD, PT, ATP/SMS and Elizabeth Cole MSPT, ATP

Patient Name: ___________________________

Describe general posture in sitting: ____

____

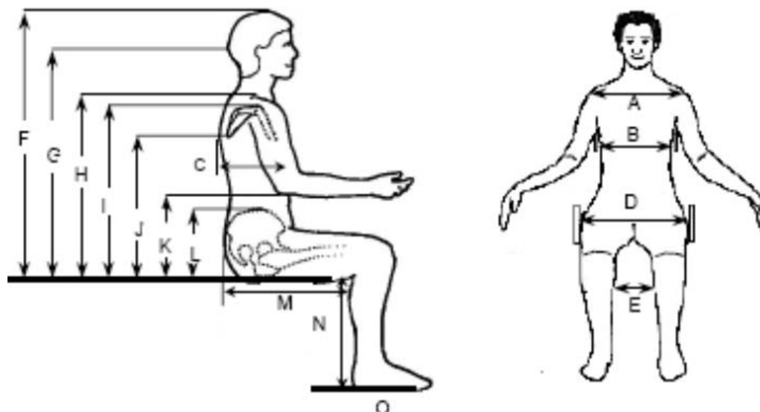
ANATOMICAL MEASUREMENTS

Client weight: _________

Client height: _________

Dominant hand: ❒ Right

❒ Left



Measurement in Sitting (inches)				Measurement in Sitting (inches)		
	Right	Left			Right	Left
A: Shoulder width				H: Seat to top of shoulder		
B: Chest width				I: Seat to lateral edge of scapula		
C: Chest depth (front-back)				J: Seat to bottom of scapula		
D: Hip width				K: Seat to elbow		
** Asymmetrical hip width				L: Seat to PSIS of pelvis		
E.: Between knees				M: Back of buttocks to back of knee		
F: Seat to top of head				N: Knee to heel		
G: Seat to occiput				O: Foot length		

** For asymmetric width (windswept LEs, scoliosis, fixed LE abduction – measure width at widest point

Comments: ____

____

MOBILITY EQUIPMENT TRIALED:

Manual wheelchair (*describe type and set-up*):____

____

____

Results:____

____

____

Power wheelchair (*describe type, set-up, programming*):_____________________________________

____

____

Results:____

____

____

Copyright © September 2015 Laura Cohen PhD, PT, ATP/SMS and Elizabeth Cole MSPT, ATP

Seating and components (*describe type and supports*):____

____

____

Results: ____

____

____

RECOMMENDATIONS: List the make and model of the base and all accessories and the rationale for their choice. The features of the base and accessories must be medically justified in the clinical documentation.

Equipment Base or Accessory	Rationale

Copyright © September 2015 Laura Cohen PhD, PT, ATP/SMS and Elizabeth Cole MSPT, ATP

Equipment Base or Accessory	Rationale

PLAN: ____

____

____

I certify that I am a RESNA Certified ATP who specializes in wheelchairs and that I have had direct in-person involvement in the wheelchair selection for the above client.

Name (Print): ____ ATP ID# ___________________

Signature: ____ Date: _______________________

Company: ____

Copyright © September 2015 Laura Cohen PhD, PT, ATP/SMS and Elizabeth Cole MSPT, ATP