EDUCATION IN MOTION

WHERE THEORY MEETS PRACTICE

PLEASE SEE THE DISCLAIMER INFORMATION PROVIDED ON THE LAST PAGE OF THIS DOCUMENT

Seating & Mobility Evaluation

Patient Information:

Name:_____
Address:_____
_____
Phone:_____
Email:_____
Funding Source:_____

Date of Evaluation:_____
Sex:_____
Age:_____
Height:_____
Weight:_____
Primary Caregiver:_____
Caregiver Phone:_____

Physician:_____
Therapist:_____
Therapist:_____
Supplier:_____
Supplier Company:_____
Supplier Phone:_____
Referred By:_____

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:

O2, Ventilator:_____ Age: ____ Bath Equipment: _____ Age: ____
Augmentive Communication Device:_____ Mounting: _____
Comments: _____
_____

Home Environment:

❑ House ❑ Apt ❑ Asst Living ❑ Long Term Care Facility/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: _____
Eductional Requirements: _____
Terrain Encountered: _____
Typical Distance: _____
Other: _____

Cognitive / Visual / Hearing Status:

Memory Skills:	❑ Intact	❑ Impaired	Comments _____
Problem Solving:	❑ Intact	❑ Impaired	Comments _____
Judgement:	❑ Intact	❑ Impaired	Comments _____
Attn/Concentration:	❑ Intact	❑ Impaired	Comments _____
Vision:	❑ Intact	❑ Impaired	Comments _____
Hearing:	❑ Intact	❑ Impaired	Comments _____
Communication:	❑ Intact	❑ Impaired	Comments _____

Seating & Mobility Evaluation *(Continued)*

Ambulation

❑ Unable ❑ With Device

Distance:_____

Falls:_____

Other Safety Issues: _____

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:	❑	❑	❑		_____
Grooming/Hygiene:	❑	❑	❑		_____
Meal Prep:	❑	❑	❑		_____
Home Management:	❑	❑	❑		_____
Bowel Management:	❑ Continent		❑ Incontinent		_____
Bladder Management:	❑ Continent		❑ Incontinent		_____

Wheelchair Management:

	Indep	Assist	Unable	N/A	Comments:
Bed ⟷ W/C Transfers	❑	❑	❑	❑	_____
W/C ⟷ Commode Transfers	❑	❑	❑	❑	_____
Manual W/C Propulsion	❑	❑	❑	❑	_____
Operate Power W/C Std. Joystick	❑	❑	❑	❑	_____
Operate Power W/C Alt. Controls	❑	❑	❑	❑	_____
Able to perform Weight Shifts	❑	❑	❑	❑	_____

Bed Confined without W/C ❑ Yes ❑ No

Activity Level: _____

Additional Comments: _____

_____

Sensation:

❑ Intact ❑ Impaired ❑ Absent Hx of Pressure Sores ❑ Yes ❑ No Current Pressure Sores ❑ Yes ❑ No

Comments: _____

_____

Mode of Weight Shift

Mode of Weight Shift Method: ❑ Independent ❑ Dependent ❑ Assisted

Describe Effectiveness: _____

Describe Duration: _____

Describe Frequency: _____

Cognition

Judgement:_____

Attn / Concentration:_____

Vision:_____

Goals:

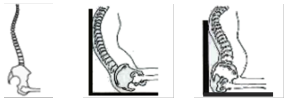
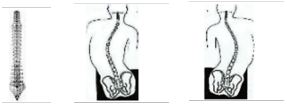
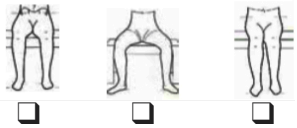
❑ Seating System ❑ Mobility Base ❑ Other: _____

Comments: _____

_____

_____

MAT Evaluation:

	POSTURE:	FUNCTION:	COMMENTS	SUPPORT NEEDED
HEAD & NECK	❑ Functional ❑ Flexed ❑ Extended ❑ Rotated ❑ Lat Flexed ❑ Cervical Hyperextension	❑ Good Head Control ❑ Adequate Head Control ❑ Limited Head Control ❑ Absent Head Control		
UPPER EXTREMITY	**SHOULDERS** **Left** / **Right** ❑ Functional ❑ Functional ❑ protracted ❑ protracted ❑ retracted ❑ retracted ❑ subluxed ❑ subluxed	**R.O.M.** **Strength:**		
	ELBOWS **Left** / **Right** ❑ Flexed ❑ Flexed ❑ Extended ❑ Extended	**R.O.M.** **Strength:**	**Left Comment:** **Right Comment:**	
WRIST & HAND	**Left** **Right**	**Strength/Dexterity:**	**Left Comment:** **Right Comment:**	
TRUNK With Functional Limits (WFL)	**Anterior/Posterior**  ❑ WFL ❑ Thoracic Kyphosis ❑ Lumbar Lordosis ❑ Non-reducible ❑ Reducible ❑ Partly Flexible ❑ Other	**Left Right**  ❑ WFL ❑ Convex Left Scoliosis ❑ Convex Right Scoliosis ❑ Non-reducible ❑ Reducible ❑ Partly Flexible ❑ Other	**Rotation**  ❑ Neutral ❑ Forward on Left ❑ Forward on Right ❑ Non-reducible ❑ Reducible ❑ Partly Flexible ❑ Other	
PELVIS	**Anterior/Posterior**  ❑ Neutral ❑ Posterior ❑ Anterior ❑ Fixed ❑ Flexible ❑ Partly Flexible ❑ Other	**Obliquity**  ❑ WFL ❑ Lower on L ❑ Lower on R ❑ Fixed ❑ Flexible ❑ Partly Flexible ❑ Other	**Rotation**  ❑ WFL ❑ Forward on L ❑ Forward on R ❑ Fixed ❑ Flexible ❑ Partly Flexible ❑ Other	
HIPS	**Position**  ❑ Neutral ❑ ABduct ❑ ADduct ❑ Fixed ❑ Subluxed ❑ Partly Flexible ❑ Dislocated ❑ Flexible	**Windswept**  ❑ Neutral ❑ Right ❑ Left ❑ Fixed ❑ Other ❑ Partly Flexible ❑ Flexible	**Range of Motion**  **Left** / **Right** ❑ Flex: _____° ❑ _____° ❑ Ext: _____° ❑ _____° ❑ Int Rot: _____° ❑ _____° ❑ Ext Rot: _____° ❑ _____°	

MAT Evaluation: *(Continued)*

	POSTURE:	FUNCTION:		COMMENTS:
KNEES & FEET	**Knee R.O.M.** **Left** ❑ WFL ❑ Flex ____° ❑ Ext _____° **Right** ❑ WFL ❑ Flex ____° ❑ Ext _____°	Strength: _____ _____ Hamstring R.O.M. Limitations: _____ _____	**Foot Positioning** ❑ WFL ❑ L ❑ R ❑ Dorsi-Flexed ❑ L ❑ R ❑ Plantar Flexed ❑ L ❑ R ❑ Inversion ❑ L ❑ R ❑ Eversion ❑ L ❑ R	_____ _____ _____ _____ _____ _____ _____
MOBILITY	**Balance** **Sitting Balance** ❑ WFL ❑ Min Support ❑ Mod Support ❑ Unable **Standing Balance** ❑ WFL ❑ Min Support ❑ Mod Support ❑ Unable	**Transfers** ❑ Independent ❑ Min Assist ❑ Max Assist ❑ Sliding Board ❑ Hoist Required	**Ambulation** ❑ Unable to Ambulate ❑ Ambulates with Assist ❑ Ambulates with Device ❑ Independent without Device ❑ Indep. Short Distance Only	_____ _____ _____ _____ _____ _____ _____ _____

Seating & Mobility Evaluation *(Continued)*

RECOMMENDATIONS:

Mobility Base & Components	Justification

Seating System & Components	Justification

Therapist Signature _____ Date:_____

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

References:

Buck, S. N. (2009). *More than 4 wheels: Applying clinical practice to seating, mobility and assistive technology.* Milton, ON: Therapy NOW!

Lange, M. L., & Minkel, J. (2017). *Seating and wheeled mobility: A clinical resource guide.* Thorofare, NJ: Slack Incorporated.

Spinal Seating Professional Development Program: Agency for Clinical Innovation. (n.d.). Retrieved from http://www.aci.health.nsw.gov.au/networks/spinal-cord-injury/spinal-seating.

Zollars, J. A. (2010). *Special seating: An illustrated guide.* Albuquerque, NM: Prickly Pear Publications.

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Sunrise Medical (US) LLC, Fresno, CA 93727
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800.333.4000 www.SunriseMedical.com/EIM