Seating/Mobility Evaluation

PATIENT INFORMATION:

Name:		Date Referred:		Date Seen:	
Address:		Phone:		Physician:	
		Age:	Sex:	OT:	
Funding:		Height:		PT:	
Referred By:		Weight:		Other:	

Reason for Referral:

Patient Goals:

Caregiver Goals:

MEDICAL HISTORY:

Dx:

Hx:

Recent / Planned Surgeries:

Cardio-Respiratory Status:	Comments:
❒Intact: ❒Impaired:	

CURRENT SEATING / MOBILITY:

Chair: Age:

w/c Cushion: Age:	**w/c Back**: Age:

Reason for ❒Replacement / ❒Repair / ❒Update:

HOME ENVIRONMENT:

❒House ❒Apt ❒Asst Living ❒LTCF ❒Alone ❒w/ Family-Caregivers:

Entrance: ❒Level	❒Ramp	❒Lift	❒Stairs	Entrance Width:

w/c Accessible Rooms: ❒yes ❒no	Narrowest Doorway to Access:

Comments:

COMMUNITY ADL:

TRANSPORTATION: ❒Car ❒Van ❒Bus ❒Adapted w/c Lift ❒Adapted w/c Lift ❒ Ambulance ❒Other:

Driving Requirements:

Employment Requirements:

Educational Requirements

Other

COGNITIVE / VISUAL 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:
Other:	❒Intact:	❒Impaired:	Comments:

Continued

Seating/Mobility Evaluation Continued

ADL STATUS:

	Indep	Assist	Unable	Comments
Dressing/Bathing:	❒	❒	❒	
Feeding:	❒	❒	❒	
Grooming/Hygiene:	❒	❒	❒	
Meal Prep	❒	❒	❒	
Home Management	❒	❒	❒	
Bowel Mngmnt:	❒Continent	❒Incontinent		
Bladder Mngmnt:	❒Continent	❒Incontinent		

WHEELCHAIR SKILLS:

	Indep	Assist	Unable	N/A	Comments
Bed ↔ w/c Chair Transfers	❒	❒	❒	❒	
w/c ↔ Commode Transfers	❒	❒	❒	❒	
Manual w/c Propulsion:	❒	❒	❒	❒	
Operate Power w/c: Std. Joystick	❒	❒	❒	❒	
Operate Power w/c: w/ Alternative Controls	❒	❒	❒	❒	
Able to perform Weight Shifts	❒	❒	❒	❒	
Bed Confined without w/c	❒Yes	❒No	Hours spent sitting in w/c each day:		
Additional Comments:					

SENSATION:

❒Intact ❒Impaired ❒Absent	Hx of Pressure Sores ❒Yes ❒No	Current Pressure Sores ❒Yes ❒No
Comments:		

GOALS: ❒ **SEATING SYSTEM** ❒ **MOBILITY BASE** ❒**OTHER:**

RECOMMENDATIONS:

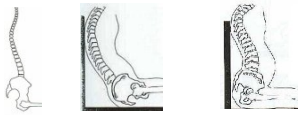
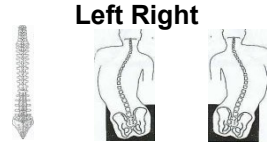
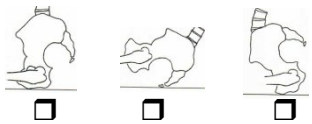
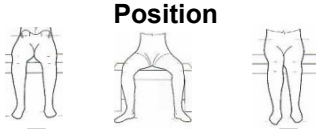
Mobility Base & Components	Justification

Seating System & Components	Justification

Therapist's Signature: _____ Date: _____

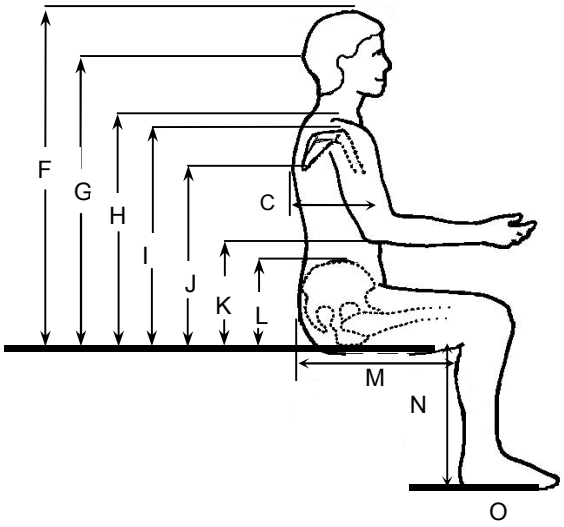
Physician's Signature: _____ Date: _____

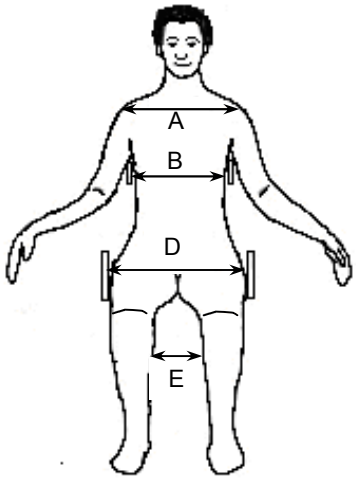
MAT Evaluation:

	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 ❒elev / dep ❒elev / dep ❒pro-retract ❒pro-retract ❒subluxed ❒subluxed	**R.O.M.** **Strength:**		
	ELBOWS **Left** / **Right** ❒Flexed ❒Flexed ❒Extended ❒Extended ❒ ❒	**R.O.M.** **Strength:**		
WRIST & HAND	**Left** / **Right**	**Strength / Dexterity:**		
TRUNK	**Anterior / Posterior**  ❒ WFL ❒ ↑ Thoracic Kyphosis ❒ ↑ Lumbar Lordosis ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒	**Left Right**  ❒ WFL ❒ Convex Left ❒ Convex Right ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒	**Rotation**  ❒ Neutral ❒ Left ❒ Right ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒	
PELVIS	**Anterior / Posterior**  ❒ Neutral ❒ Posterior ❒ Anterior ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Obliquity**  ❒ WFL ❒ Convex ❒ Convex ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Rotation**  ❒ WFL ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	
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 R: ____° ____° Ext R: ____° ____°	

MAT Evaluation: Cont'd

KNEES & FEET	**Knee R.O.M.** Left / Right ❒ WFL ❒ WFL ❒ Flex_____° ❒ Flex_____° ❒ Ext _____° ❒ Ext _____°	Strength: Ham String ROM Limitations:	**Foot Positioning** ❒ WFL ❒L ❒R ❒ Dorsi-Flexed ❒L ❒R ❒ Plantar Flexed ❒L ❒R ❒ Inversion ❒L ❒R ❒ Eversion ❒L ❒R	Foot Positioning Needs:
Mobility	**Balance** Sitting Balance: / Standing Balance ❒ WFL ❒ WFL ❒ Min Support ❒ Min Support ❒ Mod Support ❒ Mod Support ❒ Unable ❒ Unable	**Transfers** ❒ Independent ❒ Min Assist ❒ Max Asst ❒ Sliding Board ❒ Lift / Sling Required	**Ambulation** ❒ Unable to Ambulate ❒ Ambulates with Asst ❒ Ambulates with Device ❒ Independent without Device ❒ Indep. Short Distance Only	





Neuro-Muscular Status:
(Tone, Reflexive Responses, etc.)

	Measurements in Sitting:	Left	Right		
	A: Shoulder Width				Hip Flexion
	B: Chest Width			**H:**	Top of Shoulder
	C: Chest Depth (Front – Back)			**I:**	Acromium Process (Tip of Shoulder)
	D: Hip Width			**J:**	Inferior Angle of Scapula
	** Asymmetrical Width			**K:**	Elbow
	D: Hip Width			**L:**	Iliac Crest
	E: Between Knees			**M:**	Sacrum to Popliteal Fossa
	F: Top of Head			**N:**	Knee to Heel
	G: Occiput			**O:**	Foot Length

Additional Comments:

** Asymmetrical Width: i.e., windswept or Scoliotic posture; widest point to widest point

Therapist's Signature _____ Date: _____
Physician's Signature: _____ Date: _____