

**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, Psychiatrist Signature

Date

TSC 8/06