Long Island Select Healthcare

SEATING AND MOBILITY INTAKE

NAME:	D.O.B.:	DATE:
Name of Person Completing Form:	DATE OF REFERRAL	

REASON FOR WHEELCHAIR REFERRAL

- ☐ Initial Request
- ☐ Current Equipment is inappropriate
- ☐ Uncomfortable
- ☐ Not accessible to environments
- ☐ Patient request
- ☐ Modifications
- ☐ Does not fit
- ☐ Multiple Repairs
- ☐ Broken
- ☐ Need Accessories
- ☐ Poor Seating
- ☐ Other_____

GENERAL INFORMATION

Patient Address:_____

Phone #:_____

Referring Provider_____ Phone #:_____

Address:_____

PCP:_____ Phone #:_____

Address:_____

Person responsible for equipment:_____Phone #:_____

Address:_____

Referring Agency_____

Contact Person:_____ Phone # _____

Service Coordinator_____ Phone # _____

FUNDING INFORMATION ID Numbers

- ☐ Private Ins: _____
- ☐ Medicare: _____
- ☐ Medicaid: _____
- ☐ Other: _____

PREFERENCE OF WHEELCHAIR VENDOR: ☐ No ☐ Yes Name _____

GENERAL MEDICAL HISTORY

A medical summary and history of the patient:

_____

_____

_____

Onset:_____ Disease process: ____Stable ____Progressive

Medications:_____

_____

PMH/Surgeries:_____

_____

Planned Surgeries:_____

_____

Allergies:_____

Additional medical history and recent changes _____

_____

_____

Urinary ☐Continent ☐Incontinent

Bowel ☐Continent ☐Incontinent

Height:_____Weight:_____lbs.

☐Stable ☐Steady increase ☐ Fluctuation

Pain:_____

Edema Location:_____ ☐MIN ☐MOD ☐SEVERE

SENSATION:

☐Intact ☐Impaired ☐Absent (list areas impacted):_____

_____

SKIN INTEGRITY:

Past History of Pressure Ulcer: ☐Yes ☐No Date_____

Current skin condition ☐Intact ☐Stage 1 ☐Stage 2 ☐ Stage 3 ☐Stage 4

Location:_____

Describe:_____

At Risk From: ☐Prolonged sitting ☐TLSO ☐AFO

Pressure Relief: ☐Independent ☐Assisted ☐Dependent

Plan of Care (related to skin integrity, positioning schedule, treatment:_____

_____

_____

VISION

Normal ☐Yes ☐No Describe_____

Glasses ☐Yes ☐No

HEARING

Normal ☐Yes ☐No Describe_____
Hearing Aide ☐Yes ☐No

RESPIRATION

☐Normal ☐SOB

☐Oxygen ☐day ☐night

Endurance: ☐Normal ☐Good ☐Fair ☐Poor

Adequate for breath supply ☐Yes ☐No
Adequate for Speech ☐Yes ☐No
Vent Dependent ☐Yes ☐No
O2 Frequency_____
History of Chronic Congestion ☐Yes ☐No

COGNITIVE STATUS

☐Normal ☐Functional ☐Impaired – Level_____

Safety Awareness ☐Yes ☐No

Ability to follow directions ☐Yes ☐No

Behavioral problems ☐Yes ☐No

SPECIAL NEEDS:_____

LANGUAGE STATUS: ☐Verbal ☐Non Verbal

Primary language_____

Other language_____

Augmentative communication system (speech device) ____Functional ____Impaired

Type/make/mode:_____

ACTIVITIES OF DAILY LIVING

	Independent	Assisted	Passive	Comments/Equipment:
Feeding				
Bathing				
Grooming				
Dressing				
Toileting				
Telephone				
Writing				
Transfers				

CURRENT ASSISTIVE TECHNOLOGY AND MOBILITY DEVICE(S)

List All Assistive Technology Equipment and **year received**

☐ Manual W/C _____ ☐ Power W/C_____
☐ Walker/cane/crutches_____ ☐ Shower/bath Chair_____
☐Commode Chair_____ ☐ Adapted Computer_____
☐ Speech Device_____ ☐ EADL _____

How many hours per day are spent in the following?

Manual Wheelchair		Power Wheelchair	
Bed		Floor/Mat	
Couch		Dining Chair	
Commode		Shower chair	
Recliner		Stander/Standing	
Bus/Car		Walking	
Other_____			

RELATED SERVICES CURRENTLY RECEIVING:

☐Primary Care ☐MH ☐Dental
☐Sp. Therapy ☐Occupational Therapy ☐Physical Therapy
☐Splinting ☐Orthotics ☐Other_____

CAREGIVER SUPPORT

Home health aide services: _____hours per week
Respite services: _____hours per week
Family/Caregiver assistance: _____hours per week
Other: _____hours per week
Hours without assistance: _____hours per week (max 168)

HOME ENVIRONMENT:

Type of Residence: ☐House ☐Apartment ☐Condo
☐Assisted living ☐NH ☐IRA ☐ICF

Accessibility:

Entrance ☐ Level ☐Stairs ☐Lift ☐Ramp
Living Room ☐Yes ☐No Kitchen ☐Yes ☐No
Bedroom ☐Yes ☐No Bathroom ☐Yes ☐No
Hallways ☐Yes ☐No

If not accessible, how do caregivers accommodate for lack of access_____

_____

Wheelchair storage, if not in residence describe location and address security:_____

SOCIAL/DAILY ACTIVITIES

☐School:_____ Grade_____
☐Day Program_____
☐Work_____ Days per week_____Position_____
☐Other (i.e. church, etc)_____

TRANSPORTATION:

Driving: ☐Independent ☐Independent from w/c ☐Passenger

Vehicle:

☐Car	Frequency_____
☐Mini Van	Frequency_____
☐Full size van	Frequency_____
☐Truck	Frequency_____
☐Medical Transport	Frequency_____
☐Program Transport	Frequency_____
☐W/C school bus	Frequency_____
☐Public Transportation	Frequency_____

Lift/ramp ☐Yes ☐No ☐Car top carrier ☐Other:_____

Accessibility of w/c to vehicle: ☐side door ☐Back door ☐Ramp/lift

Safety: ☐Tie downs ☐4-Point ☐Mechanical lock

Occupant Retriant ☐Yes ☐No

Location and position on van:_____

FUNCTIONAL MOBILITY EVALUATION/MOBILITY RELATED ACTIVITIES OF DAILY LIVING

Can patient independently move within the home environment using crutches? Y☐ N☐

Can patient independently move within the home environment using cane? Y☐ N☐

Can patient independently move within the home environment using walker? Y☐ N☐

Can patient use crutches/cane/walker to perform MRADL's? Y☐ N☐

Can patient independently move in the community using crutches/cane/walker? Y☐ N☐

If No to any of the above, description of impairment:_____

_____

Can patient independently move within the home environment using a manual W/C? Y☐ N☐

Can patient use manual wheelchair to perform MRADL's? Y☐ N☐

Can patient independently move in the community using manual wheelchair? Y☐ N☐

If No to any of the above, description of impairment:_____

_____

Can patient independently move within the home environment using a scooter? Y☐ N☐

Can patient use a scooter to perform MRADL's safely? Y☐ N☐

Can patient independently move in the community using a scooter? Y☐ N☐

If No to any of the above, description of impairment:_____

_____

Can patient independently move within the home environment using a power W/C? Y☐ N☐

Can patient use a power wheelchair to perform MRADL's? Y☐ N☐

Can patient independently move in the community using a power wheelchair? Y☐ N☐

If No to any of the above, description of impairment:_____

_____

Name_____