

PRE-EVALUATION for KNI Seating & Mobility Clinic FAX: 785-296-7923

Please complete this form & return it to KNI before your appointment. This information is required by Medicare, Medicaid, & insurance for funding repairs & purchases. It will also help us be prepared with equipment for trials, if possible.

Name: _____ Date: _____

Address _____

Parents or guardian's name _____

1st Phone: _____ 2nd phone: _____ Male or female
Age: _____ Birth Date: _____ Weight: _____ Height: _____

Primary Physician: _____ Address: _____ Phone #: _____
Prescribing Physician _____ Address _____ Phone # _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Primary Insurance & Policy/Group Number: _____

Secondary Insurance & Policy/Group Number: _____

Are there alternative funding sources: _____

He/She will be accompanied to the assessment by _____

MEDICAL HISTORY is significant for:

Birth History: _____

Incontinence: _____

Medication: _____

Seizures: _____ Respiratory Status: _____

Surgery/Orthopedic Intervention _____

Surgeries planned for the immediate future? NO YES _____

Vision & hearing status _____

History of skin breakdown: _____

Current Areas of Redness _____

Sensation: () Intact () Impaired () Absent _____

Sensitivity to Latex: No Yes (Note Response) _____

Other Precautions: _____

WHEELCHAIR/STROLLER

Wheelchair ___ Stroller ___ Other: _____

Manual ___ Power ___ Tilt ___ Recline ___

Brand of wheelchair _____

Serial number _____

Supplier _____

Age of system _____

Additional information:

Seating System (if any)

Seat type/name _____

Back type/name _____

Additional seating system components: _____

Age of seating system _____

Why was the client referred? Please describe any problems with the current system or any of its components

FUNCTIONAL MOBILITY:

Transfers (type, assistance, equipment needed): _____

Heights of any other equipment that is used in conjunction with transfers from the wheelchair, if different from height of seat of wheelchair) _____

Amount of time wheelchair will be used: _____ hrs/day

Sitting tolerance at this time: _____

Does propulsion style or position in chair change when client is fatigued? Yes No

Explain: _____

Hand dominance? Right Left Use of both hands? Yes No

Adequate arm & hand function for manual propulsion? Yes No

Will person use lower extremities to propel? Yes No Right leg Left leg Both legs

Does person have adequate safety awareness for self propelling? Yes No

Does person have adequate strength for propelling inclines such as ramps? Yes No On uneven terrain? Yes No

Does person have adequate endurance for propelling long distances (more than 30 feet)? Yes No

Is person able to perform self-weight shifts? Yes No

Is person able to perform self-repositioning? Yes No

CURRENT EQUIPMENT Please list additional assistive equipment used in each category

Communication: _____

Walking: _____

Bathing: _____

Eating: _____

Toileting: _____

School/ Job/ Community: _____

HOME/SCHOOL/WORK:

Client resides with: _____

School / Level of Education: _____

Special Services being provided : _____

Vocation / Place of Employment: _____

TRANSPORTATION:

Vehicle used to transport wheelchair (make, model, year): _____

Are there plans to purchase a new vehicle soon? Yes No

If yes, what make and model? _____

Additional means of transportation: _____

Does the wheelchair need to breakdown or fold? Yes No Does it need to be lightweight? Yes No

Who will be lifting the wheelchair? _____

Is a wheelchair lift used? Yes No

Is wheelchair used as a seat when driving? _____

HOME ACCESSIBILITY

Residence: Rent Own Do you have a ramp? Yes No If not, do you need a ramp? Yes No

Is the INSIDE of current home accessible to a wheelchair? Yes No

Width of narrowest door to be accessed _____

Width of narrowest hallway to be accessed _____

Will wheelchair be used on carpet? Yes No

Height of any desks/tables that need to be accessed _____

OUTSIDE ACCESSIBILITY

Terrains on which wheelchair will be used:

Gravel Grass Sidewalk/pavement

Client's hopes/goals/expectations for any new equipment and/or seating changes?

() improve posture: _____

() pressure relief: _____

() accommodate deformity: _____

() relieve pain/increase sitting tolerance: _____

() reduce influence of tone: _____

() improve functional level: _____

() allow for growth/weight gain: _____

() improve appearance: _____

() meet caregiver goals: _____

() meet transportation/vocational/school goals: _____

() repair, improve, replace current equipment: _____

() other: _____

Are client's and caregiver's goals the same or compatible? () Yes () No

Explain: _____

Other information important to consider _____

Persons completing this form

_____ DATE: _____

_____ DATE: _____

Mar09