

Wheelchair and Wheelchair Seating System Equipment Selection Report Form

Please select: NTC (Nebraska Total Care) UHC (United Health Care) Wellcare

1. Client Information		2. Evaluation (Licensed Physical or Occupational Therapist)		
Name:		Name:		
Medicaid Number:		Title/Credentials:		
Birthdate:		Facility:		
Medical Diagnoses:		Address:		
		City:	State:	Zip:
Date of Onset/Exacerbation:		Daytime Phone (with area code):		
Nursing Facility (If applicable):		E-mail Address:		
Discharge from Nursing Facility anticipated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of evaluation for this requested equipment:		
Individuals present at wheelchair evaluation:		Date last seen by Prescribing Physician:		
		Prescribing Physician Specialty:		
3. Medical Records (please attach)				
Medical Records from within the previous 6 months that support request: <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Client's Current Physical Status Using Existing Equipment				
Does Client Walk Independently with or without an Assistive Device? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, throughout residence: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, throughout community? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If client walks independently but is limited in time or distance, fill in data to right:	Max Dist:	Time Req:	Frequency:	
Does client walk only with Personal Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, fill in data to right:	Max Dist:	Time Req:	Frequency:	
Propels Manual Wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, is client independent to desired destinations? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is max distance	Method and reason for limitation	
Propels Power Wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, is client independent to desired destinations? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, what is max distance	Method and reason for limitation	
How Does Client Transfer to / from Wheelchair? <input type="checkbox"/> Independently <input type="checkbox"/> With Assistance		If with Assistance, Amount and Method:		
How Does Client Relieve Sitting Pressure? <input type="checkbox"/> Independently <input type="checkbox"/> With Assistance		If with Assistance or Technology Only, Method:		
Current pressure ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify body prominence(s) (Include ICD-10 code):				
History of pressure ulcers?: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify body prominence(s) (Include ICD-10 code):				
Current Pressure Ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number, Stages and Locations:		
History of Pressure Ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number, Stages and Locations:		
Risk of Pressure Ulcers? <input type="checkbox"/> Yes <input type="checkbox"/> No		Reasons for Risk:		

Amputations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number and Location:
Pertinent Range of Motion Impairments / Contractures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location, Type and Severity:
Cognitive / Vision / Hearing Impairments? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type and Severity:
Recent / Anticipated Changes in Physical / Cognitive Status? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify, including surgeries, weight changes, new impairments, etc.
Describe Current Sitting Postural Impairments / Abnormalities:	
5. Current Wheelchair	6. Current Seating System
Describe Wheelchair Currently Used by Client:	Describe Sitting Support Components Currently Used By Client:
Current Wheelchair: List size, brand / type of wheelchair being used:	
Client Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No	Client Owned? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date Purchased (if client owned):	Date Purchased (if client owned):
Specific Reason(s) for Replacement / Modification:	Specific Reason(s) for Replacement / Modification:
7. What components currently in use by client will be used with requested equipment?	
List components:	
8. Equipment Recommendation and Justification (Additional information may be submitted on separate sheet if necessary)	
Equipment recommendation / justification - Give objective observation to include specific details for the recommendation:	
Equipment Recommended (include brand, model, pertinent dimensions if not provided elsewhere)	Medical Justification (includes how a client's medically-related impairments/activity limitations will be reduced or prevented by these on-standard items)
Wheelchair Frame:	
Wheelchair Specialty Features:	
Seat Support:	
Back Support:	
Trunk Supports:	
Chest Supports:	
Armrests:	
Legrests:	
Footplates:	
Headrest:	
Other (including pelvic support (seat belt) as needed:	

9. Other Equipment Considered that Might Meet Client's Needs and Rationale for Elimination:

List Equipment

10. Is nursing facility wheelchair available to meet client's needs:

Yes No Not Applicable

Give details on what options the NF owns, and why those options cannot meet the member's basic needs not the member's every need.

11. Expected Client Benefits of Recommended Equipment:

Expected Length of Need: 1-3 Months 3-6 Months 6-8 Months 8-12 Months >12 Months

Hours / Day Wheelchair/Seating System to be Used: <2 Hours 2-6 Hours 6-12 Hours >12 Hours

Expected Length of Need: 1-8 8-16 >16 8-12 Months

Accessibility with Equipment:

Residence: Yes No

Transportation: Yes No

School: Yes No

Community: Yes No

If not nursing facility, please describe accessibility of client's living environment to requested wheelchair:

Client Trial with Equipment: Yes No

Results of Trial:

Provide information regarding quantitative goals, expected outcomes or specific benefits for client use of requested equipment in functional terms (reduction of activity limitations or participation restrictions):

Additional information not provided elsewhere justifying medical need of requested equipment:

12. Signatures

Therapist's Signature/Credentials:

Date:

Physician's Signature:

Date:

Therapist / Physician: Submit the completed Form MS-79 to the Medical Equipment Supplier.