VERMONT

State of Vermont
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Agency of Human Services

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Wheelchair Positioning Evaluation and Prescription Form

Complete this form entirely. Leave no spaces blank.

December 2015

Date: _____ Beneficiary Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Contact Person: _____

Insurance(s): _____ Policy #: _____

Medical Conditions (include onset dates): _____

_____

_____

FUNCTIONAL LEVELS

Bed Mobility: _____

Transfers (technique, assist level): _____

Ambulation (distances, devices, assist): _____

_____

Propulsion technique (specify equipment, limbs used): _____

_____

(**Over 21 only**):

- Check the **mobility related activities of daily living (MRADLs)** that cannot be accomplished without the requested device. ☐ Feeding ☐ Dressing ☐ Grooming ☐ Bathing
- Check the nature of the **mobility limitation** that significantly impairs the ability to participate in MRADL activity:
  - ☐ Prevents the accomplishment of the MRADL(s).
  - ☐ Places the patient at reasonably heightened risk of morbidity or mortality in the attempt to perform MRADL(s).
  - ☐ Prevents completion of the MRADL(s) in a reasonable time frame.
- ☐ Check if the beneficiary is unable to access authorized medical transportation to medical services without the requested device.
- ☐ Check if the beneficiary **cannot** functionally ambulate within the home environment and/or a radius of 100 feet.

Comments: _____

_____

_____