**ADAPTIVE POSITIONING DEVICES**

**Instructions:** Complete all fields of this form to avoid delays and denials for requested services.

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| **Member Information** | | | | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_ | | Medicaid ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Medical Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Height: \_\_\_\_\_\_\_\_\_ | | Weight**:** \_\_\_\_\_\_\_\_\_ |
| Transfer Technique: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Ambulatory Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Physical Plant of Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| **Type of Device Needed** | | | |
| Adaptive seating positioning device | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Adaptive bed support | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Adaptive car support | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Type of Accessories Needed (Check All That Apply)** | | | |
| Adjustable armrests | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Adjustable leg rests | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Foot platform | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Lateral supports | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Pelvic belt | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Chest harness | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Pommel | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Tray | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| ☐ Backrest | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| ☐ Wheeled | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| ☐ Head support | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| ☐ Reclining | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| ☐ Tilt in space | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| ☐ High-low base | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| ☐ Outdoor base | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Other | | **Medical Necessity Rationale:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Successful trial:** | Yes  No | | |
| **Other devices trialed/considered that did not meet medical need:** | | | |
| Commercially available devices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Adaptive devices: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Assessment:** | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Therapist Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |