



Powered Mobility Outpatient Evaluation Intake Questionnaire

Rehabilitation Therapies Department

Please complete the questionnaire below to the best of your ability. Obtain the information requested from school or medical reports and send it with the questionnaire to the address at the bottom of page 2. After we receive your completed questionnaire, we'll contact you to set up an appointment. Because this type of assessment is complex, we need to focus on to the powered wheelchair issue during the appointment. Other equipment, therapy, or education concerns should be addressed at a separate appointment. If you have any questions, please contact Gillette Rehabilitation Therapies at 651-229-3900.

Questionnaire Completed on: _____
Patient Name: _____ Date of Birth ___/___/___ Height _____ Weight _____
Address _____ City _____ State ___ ZIP _____
Phone: _____ Diagnosis: _____
MD Referring: _____ Private Insurance MA/Tefra
Parents/Guardian/Contact Person: _____ Phone: _____
Address _____ City _____ State ___ ZIP _____
Is individual seen by an occupational or physical therapist? Yes No
Physical Therapist's Name: _____ Phone _____ Frequency _____
Occupational Therapist's Name: _____ Phone _____ Frequency _____
1. What type of wheelchair does the individual use now? Manual Power Stroller None Other
2. Describe the individual's seating system: _____ Is it removable? Yes No
3. Can the individual propel the wheelchair? _____
4. Has the individual ever tried a powered wheelchair, powered toy, or other powered vehicle? Yes No
If yes, describe this trial _____
5. Does the individual use a joystick or a switch to control a computer or video game at home or school?
Yes No, If yes, describe _____
Which hand or body part is used to access the joystick or switch? _____
6. Does the individual go to school or work on a bus? Yes No With a lift Without a lift
7. Do you have access to a Car Van Lift Van
8. Does the individual have a hearing or vision impairment? Yes No If yes, describe _____
9. In what type of situations would you expect the individual to use a powered wheelchair?
School Community Work Home Other: _____
10. If a powered wheelchair is recommended, it is very important that you find out about insurance payment and other funding sources, when necessary. Have you looked into payment issues? Yes No
11. Current Equipment Vendor _____



Powered Mobility Outpatient Evaluation Intake Questionnaire

Rehabilitation Therapies Department

Please enclose copies of the most recent reports as indicated below (completed within past year, if possible).

- * Physical Therapy Evaluation/Progress
* Occupational Therapy Evaluation/Progress
* IEP (Individualized Education Plan) / IFSP (Individualized Family Service Plan) or Vocational Plan
* Psychological Assessment (cognitive functioning)
* Audiological Assessment (if hearing impaired)
* Vision Assessment (if visually impairment)
* Photo of Individual in current seating

Please contact the individual's therapist/s, teacher/s, and others who would like to be involved with the patient's possible use of powered mobility, and indicate their responses below:

Name/s of teacher/s and others contacted: _____

What benefits do they see for the individual using powered mobility? _____

What concerns do they have concerning the individual using powered mobility? _____

What questions do they have for the Gillette Children's Specialty Healthcare powered mobility team? _____

If a powered wheelchair is recommended for this individual, would they be involved in training? _____

What are your expectations for this evaluation? _____

Is there any specific type of equipment about which you want information at the evaluation?

- Power scooter, Portable power chairs, Standing wheelchairs, Add-on units to manual chair, Power tilt-in-space, Environmental controls

Thank you for completing this intake questionnaire. It improves the quality of the powered mobility evaluation. Please return this form, copies of reports and the Release of Information at your earliest convenience in the attached, stamped envelope. Gillette Scheduling will then contact you to schedule the evaluation.

Return form to: (Age 16 and under) Gillette Children's Specialty Healthcare, Attn: Rehabilitation Therapies, 200 University Avenue East, St. Paul, MN 55101

(Age 17 and over) Gillette Lifetime Specialty Healthcare, Attn: Occupational Therapy, 550 County Road D, Suite 12, New Brighton, MN 55112

For Gillette Use Only

OT, PT, Seating (time), Rehab Engineer, Vendor (family should arrange)

Need Physician Referral Yes No

Reviewed by Date

Scheduled by Date