



Instructions

- Please print or type all information.
- You must return this form to the requestor and accompany all wheeled mobility requests.
- Complete Section I and Section V for standard wheelchair justification.
- Complete Section I through Section V for specially sized or constructed wheelchair, wheelchair with custom molded seating or specially adaptive positioning devices, power wheelchair and three-wheeled vehicle justification.

Section I - General information	
Injured worker's name	Claim number
Diagnosis, include description and ICD-10 code	Prognosis
Type of present wheelchair	Age of wheelchair
Describe the problem with the present equipment:	
Describe the equipment that is being requested:	
Describe the three most important facts this reviewer should be aware of: 1. 2. 3.	
Are there any medical conditions which are unrelated to the allowed injury? ☐ Yes ☐ No If yes, please describe:	
Section II - Medical/physical/functional status	
Cardio-respiratory status:	
Tone/movement:	
Orthopedic considerations:	
Cognitive level:	
Visual/perceptual deficits:	
Clinical observations	
Weight:	Height:
Sitting posture:	Balance:
Pelvic tilt:	Pelvic obliquity:
Leg position:	Lumbar lordosis:
Thoracic kyphosis:	Scoliosis:
Head position:	Shoulder/scapula position:
Skin condition/integrity	
Susceptible to decubitus ulcers ☐ Yes ☐ No If yes, explain	
Sensation:	Bowel/bladder status:
Present/history of ulcers:	Location coccyx:
Location ischial tuberosity:	Location spinous process:
Location trochanter:	Time spent per day in a wheelchair:
Wheelchair dependent ☐ Yes ☐ No If yes, explain	

Section II - Medical/physical/functional status - continued		
Functional status		
Upper extremity function		
ROM limitations		
Muscle strength limitations		
ADL status		
Lower extremity function		
Transfers	Wheelchair propulsion	
Ability to perform pressure relief		
Wheelchair accessibility of residence		
Method of wheelchair transportation		
Section III - Equipment justification		
Is there other related equipment to be evaluated or considered? ☐ Yes ☐ No If yes, explain		
Therapeutic objectives/benefits of prescribed equipment:		
Other special considerations:		
Length of time wheelchair will be needed:		
Section IV - Equipment prescription		
Mobility base:		
Seating/positioning components:		
Notes:		
Section V - Evaluator		
Evaluator's signature	Credentials ☐ Physician ☐ P.T. ☐ O.T. L/R	License No.
Name (please print)	Phone	FAX
Address	State	9-digit ZIP Code
Email	NPI number	BWC ID