Wheelchair Clinic Screen / Assessment

Name: ____ Date: _________________

Does the wheelchair seat width and depth fit the resident / meet the needs of the resident?
Yes No /Recommendations:

Does the seat height of the wheelchair fit the resident / meet the needs of the resident?
Yes No /Recommendations:

Does the back of the wheelchair fit the resident / meet the needs of the resident?
Yes No /Recommendations:

Do the current foot pedals fit the resident / meet the needs of the resident?
Yes No /Recommendations:

Can the resident manage the foot pedals?
Yes No /Recommendations:

Can the resident lock own brakes?
Yes No /Recommendations:

Are the current arm rests meeting the needs of the resident?
Yes No /Recommendations:

Is the Resident able to propel self in current wheelchair?
Yes No /Recommendations:

Is the resident able to reposition self in wheelchair?
Yes No/Recommendations:

Does the wheelchair require maintenance?
No Yes /Recommendations:

Is there a hx of falling out of wheelchair
No Yes /Recommendations:

Does the resident have postural issues or pain in the current wheelchair?
No Yes / Recommendations:

Does the resident have orthopedic deformities needing a customized wheelchair assessment?
No Yes / Recommendations:

Do any of the recommendations demonstrate the need for a skilled therapy evaluation?
No Yes / Recommendations: PT Eval OT Eval

Therapist: ____