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System!

# Evaluation sheet

# Individualized treatment

for the determination of proper seating and postural support systems

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## Patient information

**Last name, First name** _____ **Date of birth** _____

**Address** _____

**Telephone** _____ **Fax** _____

**Insurance policy no.** _____ **Health insurance provider** _____

**Care stage** ☐ I ☐ II ☐ III

**Residential environment** ☐ At home ☐ permanently ☐ occasionally ☐ Nursing home / facility ☐ permanently ☐ occasionally

**Attends** ☐ Kindergarten ☐ School ☐ Workshops / facility

**Treatment to date** ☐ Electric wheelchair ☐ Active wheelchair ☐ Seat shell with undercarriage

☐ Buggy ☐ AKTIVLINE ☐ _____

**Reason for change** ☐ Growth / Development ☐ Wear

☐ New treatment ☐ First treatment

**Diagnosis** _____

_____

**Prescription** _____

_____

## Patient profile

**Weight (kg)** _____ **Height (cm)** _____

**Sex** ☐ male ☐ female

**Able to walk?** ☐ Yes ☐ No ☐ _____

**Able to move?** ☐ Yes ☐ No ☐ _____

**Locomotion by means of** ☐ Both arms ☐ One arm ☐ Arms and legs ☐ Electrical support ☐ Accompanying person

**Maximum length of time seated** _____ hours

**Independent pressure relief** ☐ Yes ☐ No

**Evaluation of the patient**
☐ active (continue with determination of deficits)
☐ passive (continue with determination of residual activity)
☐ spastic (continue with determination of affected parts of the body)

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## Deficits (head to toe)

☐ Foot and leg misalignments

☐ No upper leg control

☐ Pelvic instability

☐ Spinal deformity

☐ Kyphosis ☐ Lordosis ☐ Skoliosis ☐ Trunk orthotic device

☐ Insufficient trunk control

☐ Insufficient hand and arm control

☐ Insufficient head control

☐ Decubitus

☐ Incontinence

## Residual activity (head to toe)

| | | good | limited | severely limited |
|---|---|---|---|---|
| ☐ Foot and leg control | | | | |
| | left | ☐ | ☐ | ☐ |
| | right | ☐ | ☐ | ☐ |
| ☐ Trunk and pelvic control | | ☐ | ☐ | ☐ |
| ☐ Arm control | | | | |
| | left | ☐ | ☐ | ☐ |
| | right | ☐ | ☐ | ☐ |
| ☐ Hand control | | | | |
| | left | ☐ | ☐ | ☐ |
| | right | ☐ | ☐ | ☐ |
| ☐ Head control | | ☐ | ☐ | ☐ |
| ☐ Active perception | | ☐ | ☐ | ☐ |

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## Spasticity

☐ Legs _____

_____

☐ Pelvis _____

_____

☐ Trunk _____

_____

☐ Arms _____

_____

☐ Head _____

_____

## Treatment result based on the evaluation sheet

☐ **Active individually customized treatment**

| | | |
|---|---|---|
| ☐ Seat | ☐ basic | ☐ specialized |
| ☐ Back | ☐ basic | ☐ specialized |
| ☐ Complete seat and back | ☐ basic | ☐ specialized |

☐ **Passive individually customized treatment**

| | | |
|---|---|---|
| ☐ Structural support (ORTHOLIGHT) | ☐ basic | ☐ specialized |
| ☐ Structural support (ERGOLINE) | ☐ basic | ☐ specialized |
| ☐ Postural support systems (in accordance with the customer's specifications) | ☐ basic | ☐ specialized |

☐ **Standardized treatments**

| | |
|---|---|
| ☐ MAGICLINE without undercarriage | Size (1-3) _____ |
| ☐ MAGICLIGHT without undercarriage | Size (0-3) _____ |
| ☐ KOMBILINE with undercarriage | Size (1-6) _____ |
| ☐ AKTIVLINE BASIS with undercarriage | Size (1-3) _____ |

☐ **Dynamic treatments**

| | | |
|---|---|---|
| ☐ AKTIVLINE with undercarriage | ☐ standardized | ☐ individualized |
| ☐ AKTIVLINE on electric wheelchair | ☐ individualized | |

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## Upgrade kits

☐ **Undercarriage** ☐ Indoors ☐ Outdoors ☐ Active wheelchair ☐ Electric wheelchair

☐ **Trapezoidal adapter unit (includes materials and mounting)**

☐ **Adapter for undercarriages** ☐ Third-party manufacturer ☐ Electric wheelchair

☐ **Leg rest** ☐ basic ☐ specialized ☐ individualized

☐ **Straps** ☐ Arms ☐ Upper body ☐ Pelvis ☐ Feet/Legs

☐ **Therapy tray table** ☐ basic ☐ specialized

☐ **Arm rest** ☐ basic ☐ specialized

☐ **Head rest** ☐ basic ☐ specialized ☐ dynamic

☐ **Molded custom contour** ☐ seat only ☐ back only ☐ head segment only ☐ complete body

## Other available services

☐ **Device leasing**

☐ **Device rental (trial phase)**

☐ **Reuse of a device**

☐ **Maintenance contract with optional warranty extension**

☐ **Growth warranty for a fixed defined period**

☐ **Binding specification of graduated repurchase values**

☐ **Use of used components (where available)**

☐ **Selection of suitable cooperation partners, including quote (e. g. electric wheelchair, third-party undercarriage, etc.)**

## Summary (result, suggested device)

## Additional information (e.g. transport, therapeutic use, residential environment, etc.)

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## Aim

## Evaluation Participants

**Medical device advisor**

Name | Telephone | Date, Signature

**Physician**

Name | Telephone | Date, Signature

**Therapist**

Name | Telephone | Date, Signature

**Family member**

Name | Telephone | Date, Signature

**Caregiver**

Name | Telephone | Date, Signature

**Other**

Name | Telephone | Date, Signature

## Date, Time

interco Contact person | Signature

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