MPS maxX

PRE-EVALUATION FORM

for Modular Power Standing System on a ROVI A3 Base

Client's First Name: _____ Last Name: _____ Record Number: _____

Height (ft/in): _____ Weight (lbs): _____ DX: _____

Other Client Info: _____

We require an Occupational Therapist or Physical Therapist with good knowledge of the client to be present during the evaluation and prescription process.

Therapist's First Name: _____ Last Name: _____ Date (dd/mm/yy): _____

Credentials: _____ Employer: _____

Phone #: _____ Email: _____

Necessary preliminary information:

Is the patient currently in a standing program? ☐ Y ☐ N

If yes, how does the patient tolerate a standing position?

Good – Fair – Poor

☐5 ☐4 ☐3 ☐2 ☐1

On average, how often/how long does the patient stand? _____

When was the last time this person stood for any length of time? _____

Are there any lower extremity joint limitations? ☐ Y ☐ N

If yes, where and degrees of limitation? _____

Do you have any concern about the person's bone integrity? ☐ Y ☐ N

If there is concern, has a bone mineral study been conducted? ☐ Y ☐ N

Is there any concern about postural hypotension? ☐ Y ☐ N

What other systems will be evaluated along with the standing feature: ☐ Tilt ☐ Tilt/Recline ☐ Elevate ☐ Power Legrest

Do you have any other concerns of safety for this patient in the standing position? ☐ Y ☐ N

If there is concern, please explain? _____

Form must be returned to Motion Concepts Customer Service before evaluation. F: 888-433-6834 or quotes@motionconcepts.com

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