



**M E D I C A L C L E A R A N C E F O R M**

**PHYSICAL ASSESSMENT FOR STANDING EQUIPMENT**

<b>Section A: Patient information</b>			
Patient name _____	Recipient identification number _____		
Diagnosis _____			
Onset date of disability _____	Date of birth _____		
Current weight _____	Current height _____		
<b>Section B: Physician Information</b>			
Provider's name _____	Provider number _____		
<b>Section C: General Physical Status</b>			
<i>*Please circle most appropriate answer. If abnormal or progress is circled, please explain in the space provided.</i>			
Cardiopulmonary status	Normal	Abnormal	Progress
Sensation/body awareness	Normal	Abnormal	Progress
Skin status	Normal	Abnormal	Progress
Sensation status	Normal	Abnormal	Progress
Muscle strength status (Specify upper and lower strength)	Normal	Abnormal	Progress
Muscle tone status	Normal	Abnormal	Progress
ROM status (Specify upper and lower ROM)	WFL (within functional limits)	Abnormal	Progress
Standing static and dynamic balance	Normal	Abnormal	Progress
Sitting static and dynamic balance	Normal	Abnormal	Progress

<b>Section D: Requires Assistance With The Following</b>				
<i>* Please circle most appropriate answer</i>				
Ambulation	Independent	Minimum	Maximum	Dependent
Transfers	Independent	Minimum	Maximum	Dependent
Propelling wheelchair	Independent	Minimum	Maximum	Dependent
Sitting	Independent	Minimum	Maximum	Dependent
Feeding	Independent	Minimum	Maximum	Dependent
Dressing	Independent	Minimum	Maximum	Dependent
Hygiene	Independent	Minimum	Maximum	Dependent
<b>Section E: Rational For Use</b>				
<i>*Please circle yes or no</i>				
To maintain bone integrity and increase bone density	Yes	No		
To improve circulation in the lower extremities	Yes	No		
To improve range of motion	Yes	No		
To decrease muscle spasms	Yes	No		
To strengthen cardiovascular system and build endurance	Yes	No		
To improve strength to the trunk and lower extremities	Yes	No		
To prevent or decrease joint muscle contractures	Yes	No		
To lessen or prevent progressive scoliosis	Yes	No		
To aid normal skeletal development	Yes	No		
<b>Section F: Special Considerations</b>				
<i>* Please circle the correct answer or fill in the blanks</i>				
What is the height range and weight capacity of the stander requested? Height range from _____ to _____      Weight capacity from _____ to _____ Additional Comments:				
What are the position needs?      Supine      Vertical      Prone      Multi-positional Additional Comments:				
What is the cost of the stander? Please individually list each requested accessory and its cost.				
How long will the stander be required?      Months _____      Years _____      Lifetime _____ Additional Comments:				
Is the nonpaid primary caregiver willing and able to be trained to use the equipment safely?			Yes	No
Additional Comments:				
<b>Assessment Completed By:</b>			<b>Date:</b>	
<b>Section G: Physician's Signature and Date</b>				
I certify the medical necessity of these items for this patient. I have examined the above-mentioned patient and to my knowledge there are no medical or surgical contraindications for the use of a stander.				
<b>Physician's signature:</b>			<b>Date:</b>	