



**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 select the most appropriate answer. If abnormal or progress is selected, please explain in the space provided.</i>				
Cardiopulmonary status	Normal	Abnormal	Progress	
Explain:				
Sensation/body awareness	Normal	Abnormal	Progress	
Explain:				
Skin status	Normal	Abnormal	Progress	
Explain:				
Sensation status	Normal	Abnormal	Progress	
Explain:				
Muscle strength status	Upper strength	Normal	Abnormal	Progress
	Lower strength	Normal	Abnormal	Progress
Explain:				
Muscle tone status	Normal	Abnormal	Progress	
Explain:				
Range of motion (ROM) status	Upper ROM	Within functional limits (WFL) WFL	Abnormal	Progress
	Lower ROM		Abnormal	Progress
Explain:				
Standing static and dynamic balance	Normal	Abnormal	Progress	
Explain:				
Sitting static and dynamic balance	Normal	Abnormal	Progress	
Explain:				

<b>Section D: Requires Assistance With The Following</b>				
<i>* Please select 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 select 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 select 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      Multipositional 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>				