

# Standing Technology Intake Evaluation

## I Client Profile

### Client Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, state, zip: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Social security #: \_\_\_\_\_

Date of birth: \_\_\_\_\_

### Parent/Guardian

Name: \_\_\_\_\_

Address: city, state, zip: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

### Primary Funding Source

Name: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Claims phone: \_\_\_\_\_

Case manager: \_\_\_\_\_

### Secondary Funding Source

Name: \_\_\_\_\_

ID #: \_\_\_\_\_

Group #: \_\_\_\_\_

Claims phone: \_\_\_\_\_

Case manager: \_\_\_\_\_

### Client's Employment/School Information

Employer/school: \_\_\_\_\_

Address: \_\_\_\_\_

City, state, zip: \_\_\_\_\_

Title/Grade: \_\_\_\_\_

Supervisor/educator: \_\_\_\_\_

# Standing Technology Intake Evaluation

## II General Physical Status

Diagnosis: \_\_\_\_\_

Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Onset of disability: \_\_\_\_\_

Medical history: \_\_\_\_\_

### Current Function:

**Ambulation:**  None  Limited  Wheelchair for mobility - Distance \_\_\_\_\_

Mild assist  Moderate assist  Maximum assist

**Transfer:**  Independent  Dependent  Assist -  1 person  2 person

Method \_\_\_\_\_

**Activities of daily living:**  Independent  Partial assist  Dependent

**Living environment:**  Home  Apartment  Institution  Single level  Multi-level  Owns  Rents

**Current stander / when obtained:** \_\_\_\_\_

**Current standing program:** \_\_\_\_\_

**Therapies:**  PT  OT  Speech  Other \_\_\_\_\_

**Transportation:**  Car  Van  Public transportation  Other \_\_\_\_\_

**Cognitive level:**  Preadiness  Readiness  On age Level  Understands safety of self & others

Comments \_\_\_\_\_

### Physical Exam:

**Sitting Balance:**  Good - hands free capability to weight shift  Fair-hands free only  
 Poor-propped & hand support  Dependent-needs external support

**Muscle Strength:** U/E  Normal  Reduced  None  
L/E  Normal  Reduced  None

### Sitting Posture:

Posterior pelvic tilt	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Anterior pelvic tilt	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Pelvic Obliquity	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Kyphosis	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Lordosis	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Scoliosis	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Head/neck hyperextension	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Leg abduction	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Leg adduction	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Wind sweeping	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other
Other	<input type="checkbox"/> None	<input type="checkbox"/> Fixed	<input type="checkbox"/> Flexible	<input type="checkbox"/> Other

### Tonal influences / reflexes in sitting:

Extensor  Flexor  ATNR  STNR  Positive support  Ankle clonus  Other \_\_\_\_\_

### Lower extremity range of motion seated:

Hip flexion (normal 0° to 125°) \_\_\_\_\_ Knee extension hip at 90° \_\_\_\_\_

Ankle \_\_\_\_\_ Other \_\_\_\_\_

**Skin integrity:**  Intact  Red area  Open area  Scar tissue  History of sores

Area:  Ischial tuberosities  Coccyx  Spine  Other

**Sensation:**  Normal  Impaired  Non-sensate Level \_\_\_\_\_

Bowel:  Continent  Incontinent  Training

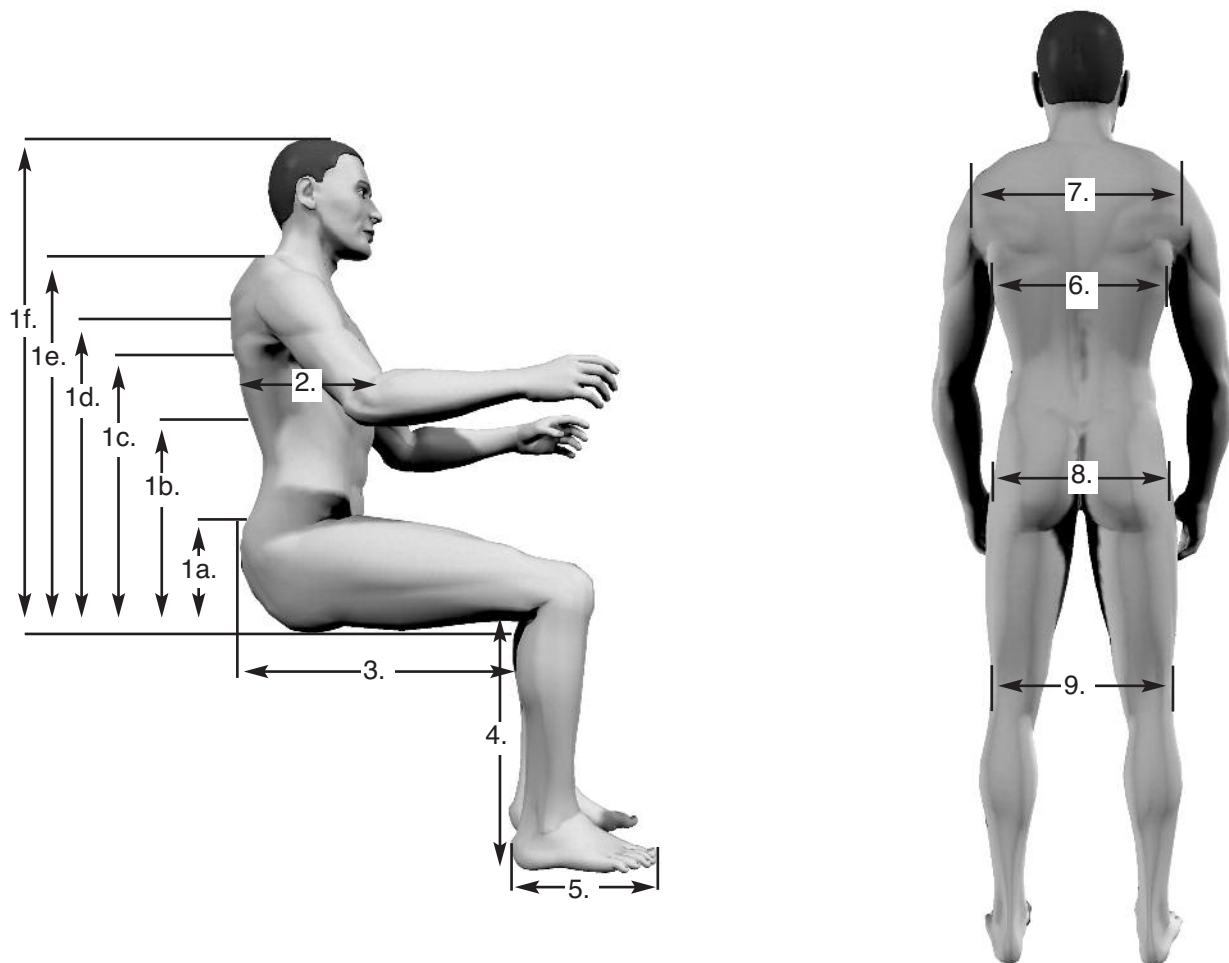
Bladder:  Continent  Incontinent  Training  Other/comments \_\_\_\_\_

# Standing Technology Intake Evaluation

## III Measurements in Sitting & Standing

1. Seat surface (*the contact point of the buttocks*) to:
  - a. PSIS
  - b. Elbows
  - c. Inferior angles of scapula
  - d. Armpit
  - e. Top of shoulder
  - f. Top of head
2. Trunk depth (*back surface to front of the ribs*)
3. Leg length (*from where the hips touch backrest to popliteal angle of knee*)
4. Back of knee to heel (*or weight-bearing area*)
5. Foot length (*with shoes & AFO's if applicable*) \_\_\_\_\_
6. Trunk width (*across chest*) \_\_\_\_\_
7. Shoulder width \_\_\_\_\_
8. Hip width \_\_\_\_\_
9. Outer knee width (*relaxed, with knees apart*) \_\_\_\_\_

Left	Right	Standing



# Standing Technology Intake Evaluation

## IV Equipment Considerations / Trials & Outcomes

1. Trial date: \_\_\_\_\_

Stander style: \_\_\_\_\_

Stander mfg.: \_\_\_\_\_

Outcome: \_\_\_\_\_

---

---

---

2. Trial date: \_\_\_\_\_

Stander style: \_\_\_\_\_

Stander mfg.: \_\_\_\_\_

Outcome: \_\_\_\_\_

---

---

---

3. Trial date: \_\_\_\_\_

Stander style: \_\_\_\_\_

Stander mfg.: \_\_\_\_\_

Outcome: \_\_\_\_\_

---

---

---

# Standing Technology Intake Evaluation

## V Standing Equipment Needed

Type of stander needed: \_\_\_\_\_

Brand name: \_\_\_\_\_

Model #: \_\_\_\_\_

### Special considerations of chosen standing equipment *(justification of accessories)*

1. Is the patient able to operate that stander independently?  YES  NO \_\_\_\_\_

2. Does the patient use a wheelchair for mobility?  YES  NO \_\_\_\_\_

3. Does the stander have adequate supports, anteriorly, posteriorly, and laterally to position the person in a symmetrical aligned standing?  YES  NO \_\_\_\_\_

4. Does the stander have enough adjustment to allow for individual fit and allow for growth changes?  YES  NO \_\_\_\_\_

5. What is the height range and weight capacity of the stander?  
From \_\_\_\_\_ to \_\_\_\_\_ weight capacity

6. Is it relatively easy to modify to meet the individuals position needs?  YES  NO \_\_\_\_\_

7. What are the environmental factors to consider (ie: room size in residence; or if a mobile stander is it easy to move on existing flooring)? \_\_\_\_\_

8. Transfer considerations/caregiver constraints. What makes the model chosen advantageous in changing positions? \_\_\_\_\_

9. Other: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Standing Technology Intake Evaluation

## VI Reasons for Standing Equipment

\_\_\_\_\_needs a stander as an adjunct to therapy on a daily basis for the following reasons:

- 1 Aid in the prevention of atrophy in the trunk and leg muscles  YES  NO \_\_\_\_\_
- 2 Improve circulation to trunk and lower extremities  YES  NO \_\_\_\_\_
- 3 Prevent formation of decubiti (pressure sores) through changing positions  YES  NO \_\_\_\_\_
- 4 Help maintain bone integrity  YES  NO \_\_\_\_\_
- 5 Improve bowel function and regularity  YES  NO \_\_\_\_\_
- 6 Reduce swelling in lower extremities  YES  NO \_\_\_\_\_
- 7 Improve range of motion  YES  NO \_\_\_\_\_
- 8 Aid kidney and bladder functions  YES  NO \_\_\_\_\_
- 9 Decrease muscle spasms  YES  NO \_\_\_\_\_
- 10 Strengthen cardiovascular system and build endurance  YES  NO \_\_\_\_\_
- 11 Improve strength to trunk and lower extremities.  YES  NO \_\_\_\_\_
- 12 Prevent or decrease joint/muscle contractures  YES  NO \_\_\_\_\_
- 13 Lessen or prevent the progression of scoliosis  YES  NO \_\_\_\_\_
- 14 Aid normal skeletal development  YES  NO \_\_\_\_\_

Please describe in detail the current problems and associated costs this client may be having due to the absence of a standing program:

---

---

---

Standing program recommendations: \_\_\_\_\_

---

---

---

Completed by: \_\_\_\_\_

Title: \_\_\_\_\_

Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_