Ohio | Bureau of Workers' Compensation

Justification of Medical Necessity for Seating/Wheeled Mobility

Instructions

- Please print or type all information.
- You must return this form to the local customer service office and accompany all wheeled mobility requests.
- Complete Section I and Section V for standard wheelchair justification.
- Complete Section I through Section V for specially sized or constructed wheelchair, wheelchair with custom molded seating or specially adaptive positioning devices, power wheelchair and three-wheeled vehicle justification.

Section I - General Information

Injured worker's name	Claim number

Diagnosis, include description and ICD-9 code	Prognosis

Type of present wheelchair	Age of wheelchair

Describe the problem with the present equipment:

Describe the equipment that is being requested there:

Describe the three most important facts this reviewer should be aware of:

1.
2.
3.

Are there any medical conditions which are unrelated to the allowed injury? ☐ Yes ☐ No If yes, please describe:

Section II - Medical/Physical/Functional Status

Cardio-respiratory status:

Tone/movement:

Orthopedic considerations:

Cognitive level:

Visual/perceptual deficits:

Clinical Observations

Weight:	Height:
Sitting posture:	Balance:
Pelvic tilt:	Pelvic obliquity:
Leg position:	Lumbar lordosis:
Thoracic Kyphosis:	Scoliosis:
Head position:	Shoulder/scapula position:

Skin Condition/Integrity

Susceptible to decubitus ulcers ☐ Yes ☐ No If yes, explain

Sensation:	Bowel/bladder status:
Present/history of ulcers:	Location coccyx:
Location ischial tuberosity:	Location spinous process:
Location trochanter:	Time spent per day in W/C:

Wheelchair dependent ☐ Yes ☐ No If yes, explain

Section II - Medical/Physical/Functional Status - Continued

Functional Status

Upper extremity function

ROM limitations

Muscle strength limitations

ADL status

Lower extremity function

Transfers	Wheelchair propulsion

Ability to perform pressure relief

Wheelchair accessibility of residence

Method of wheelchair transportation

Section III - Equipment Justification

Is there other related equipment to be evaluated or considered ☐ Yes ☐ No If yes, explain

Therapeutic objectives/benefits of prescribed equipment:

Other special considerations:

Length of time wheelchair will be needed:

Section IV - Equipment Prescription

Mobility base:

Seating/positioning components:

Notes:

Section V - Evaluator

Evaluator's signature	Credentials ☐ Physician ☐ L.P.T. ☐ O.T. L/R	License No.
Name (please print)	Phone ( )	FAX ( )
Address	State	9 digit ZIP Code