Indiana Health Coverage Programs

MEDICAL CLEARANCE FORM

PHYSICAL ASSESSMENT FOR STANDING EQUIPMENT

Section A: Patient information

Patient name _____ Recipient identification number _____

Diagnosis _____

Onset date of disability _____ Date of birth _____

Current weight _____ Current height _____

Section B: Physician Information

Provider's name _____ Provider number _____

Section C: General Physical Status

**Please select the most appropriate answer. If abnormal or progress is selected, please explain in the space provided.*

Cardiopulmonary status Explain:		◯ Normal	◯ Abnormal	◯ Progress
Sensation/body awareness Explain:		◯ Normal	◯ Abnormal	◯ Progress
Skin status Explain:		◯ Normal	◯ Abnormal	◯ Progress
Sensation status Explain:		◯ Normal	◯ Abnormal	◯ Progress
Muscle strength status Explain:	Upper strength Lower strength	◯ Normal ◯ Normal	◯ Abnormal ◯ Abnormal	◯ Progress ◯ Progress
Muscle tone status Explain:		◯ Normal	◯ Abnormal	◯ Progress
Range of motion (ROM) status Explain:	Upper ROM Lower ROM	◯ Within functional limits (WFL) ◯ WFL	◯ Abnormal ◯ Abnormal	◯ Progress ◯ Progress
Standing static and dynamic balance Explain:		◯ Normal	◯ Abnormal	◯ Progress
Sitting static and dynamic balance Explain:		◯ Normal	◯ Abnormal	◯ Progress

Section D: Requires Assistance With The Following ** Please select most appropriate answer*				
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

Section E: Rational For Use **Please select yes or no*		
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

Section F: Special Considerations

** Please select the correct answer or fill in the blanks*

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:

Assessment Completed By:	**Date:**

Section G: Physician's Signature and Date

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.

Physician's signature: **Date:**