Oregon Health Authority

Positioner Justification – Positioners for standing

All clients are evaluated as individuals. Each piece of equipment has certain functional uses which may be the same from client to client. This similarity of function allows the development of this form which is filled out specifically for the client indicated.

Client name: _____ Date of request: _____

Medicaid ID: _____ Age: _____ Date of birth _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____

Diagnosis and diagnosis code(s) from the physician:

Significant medical complications: _____

Contracture, scoliosis, and/or kyphosis *(indicate degrees)*: _____

Physical capabilities: _____

Present positioner and problems: _____

List all positioning equipment currently in use by client:

Accessibility: Has the client's living situation been evaluated for compatibility with equipment? *(Check one)*
☐ Yes ☐ No

Positioner justification

Tell us what this client will need *(check all that apply)*:
☐ Vertical standing frame: ☐ Hydraulic or ☐ Manual
☐ Prone positioner ☐ Supine positioner ☐ Modifications

Reason *(check all that apply):*
☐ Client has outgrown positioner ☐ Positioner is worn out or broken
☐ Client's capabilities have changed ☐ Client has no positioner

Justification *(check all that apply):*
☐ Aid in the prevention of atrophy in the trunk and leg muscles
☐ Improve circulation to trunk and lower extremities
☐ Prevent formation of decubiti (pressure ulcers) through changing positions
☐ Help maintain bone integrity
☐ Improve bowel function and regularity
☐ Reduce swelling in lower extremities
☐ Improve range of motion
☐ Aid kidney and bladder functions
☐ Decrease muscle spasms
☐ Strengthen cardiovascular system and build endurance
☐ Improve strength to trunk and lower extremities
☐ Prevent or decrease joint/muscle contractures
☐ Lessen or prevent the progression of scoliosis
☐ Aid normal skeletal development

Additional information:

Special considerations of chosen standing equipment

Is the patient able to operate that stander independently?			☐ Yes ☐ No
Does the patient use a wheelchair for mobility?			☐ Yes ☐ No
Does the stander have adequate supports anterior and posterior as well as laterally to position the person in a symmetrical aligned standing?			☐ Yes ☐ No
Does the stander have enough adjustment to allow for individual fit and for growth changes?			☐ Yes ☐ No
What is the height range of the stander?	From:	To:	
What is the weight capacity of the stander?	From:	To:	
Is it relatively easy to modify to meet the individual's position needs?			☐ Yes ☐ No

What are the environmental factors to consider (*e.g.,* room size in residence)?

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

Other considerations:

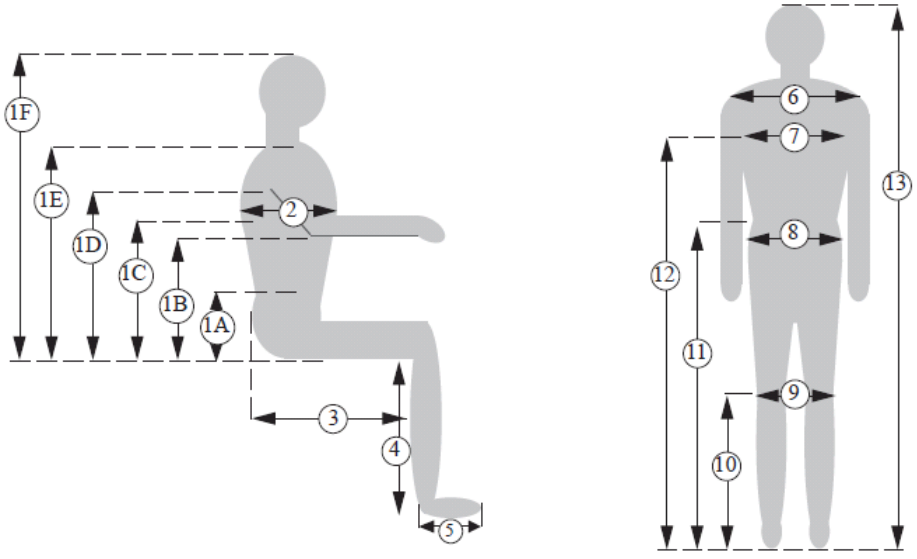
Specific accessories justification *(check all that apply)*

☐ Back support:	☐	Needs for balance, stability, or positioning assistance
	☐	Has extensor tone of the trunk muscles
	☐	Does not have trunk stability to support him/herself while being raised or while completely standing
☐ Tall back:	☐	Is over 5' 11" tall
	☐	Has no trunk control at all and needs additional support
	☐	Has more involved need for assistance with balance, stability, or positioning
☐ Hip guides:	☐	Lacks motor control and/or strength to center hips
	☐	Has asymmetrical tone which causes hips to pull to one side
	☐	Spasticity ☐ Low tone or high tone
	☐	Need for balance, stability, or positioning assistance
☐ Shoulder retractor or harness:	☐	Cannot maintain erect posture without support due to lack of motor control or strength
	☐	Kyphosis
☐ Lateral supports:	☐	Lacks trunk control to maintain lateral stability
	☐	Has scoliosis which requires support
	☐	Needs a guide to find midline
☐ Head rest:	☐	Lacks head control and cannot hold head up without support
	☐	Has strong extensor thrust pattern that requires inhibition
☐ Independent adjustable knee pads:	☐	Has severe leg length discrepancy
	☐	Has contractures in one leg greater than the other
☐ Actuator handle extension:	☐	No care giver, and able to transfer independently into standing frame, and has limited range of motion in arm and/or shoulder and cannot reach actuator in some positions

☐ Arm troughs:	☐	Has increased tone which pulls arms backward so hands cannot come to midline
	☐	Tone, strength, or control is so poor that arms hand out to side and backward, causing pain and risking injury
	☐	For posture
☐ Tray:	☐	Positioning
☐ Abductors:	☐	Reduce tone for alignment so bear weight properly
☐ Sandals (shoe holders):	☐	Dorsiflexion of the foot or feet
	☐	Planar flexion of the foot or feet
	☐	Eversion of the foot or feet ☐ Safety
☐ Other (please specify):	☐	Describe justification for other accessory:

Measurement in sitting and standing

	Left	Right	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 potential angle of knee)			
4) Back of knee to heel (or weight-bearing area)			
5) Foot length (with shoes & AFOs if applicable)			
6) Shoulder width			
7) Trunk width (across chest)			
8) Hip width			
9) Outer knee width (relaxed, with knees apart)			
10) Knee height			
11) Hip height			
12) Chest height			



Equipment trial and outcome

1st trial date:	Stander style: Stander manufacturer: Outcome:
2nd trial date *(if needed):*	Stander style: Stander manufacturer: Outcome:
3rd trial date *(if needed):*	Stander style: Stander manufacturer: Outcome:

Equipment trial outcome: _____

Specifications - *Attach copy of manufacturer's information and suggested price.*

Make and model number: _____

Standard model includes: _____

Less costly alternatives considered? ☐ Yes ☐ No

Please explain:

How long (in years) will this positioner be used? _____

How long is the positioner expected to last? _____

Requestor information

Therapist's Signature – *This section must be signed by the therapist completing this form.*

Therapist's name _____ Phone number: _____
(Please print or type)

Signature _____ Date _____

Physician's Signature – *This section must be signed by the referring physician.*

Physician's Name: _____ Phone number: _____
(please print or type)

Signature _____ Date _____

Rehabilitation Technology Supplier

Signature _____ Date _____