PHYSICIAN'S RECOMMENDATION FORM

Mobility Angels Corporation is a 501 (c)(3) nonprofit organization dedicated to providing families with children who use a wheelchair independence and mobility. We are raising funds to provide eligible families a wheelchair accessible vehicle. All families should be able to travel to places, events, and activities away from their home; when they want to as well as when they need to. They should also be able to do it safely without injuring themselves or their child. Your patient is applying for eligibility.

CANDIDATE'S INFORMATION	
PATIENT NAME:	**DATE OF BIRTH:**
DIAGNOSIS (Include ICD-10 Code/s):	
CURRENT WEIGHT:	**CURRENT HEIGHT:**
Does your patient use a wheelchair for mobility and positioning to attend office visit? _____ YES _____ NO	
Is your patient's primary means of functional mobility using a wheelchair? ____YES ____NO	
CAR TRANSPORTATION STATUS:	
Current Equipment used, if any, for Car Transportation:	
Is the patient currently being lifted into the car/car seat? ____YES ____NO Does initial lifting occur below waist level of caregiver? _____ YES _____NO Does Turning/twisting occur during the transfer of patient from WC to car? ____YES ___NO Does Bending occur during the transfer of patient from WC to car? ____YES ____NO Does patient need to be held away from caregiver's body while transfering? ____YES ____NO	
Will the patient benefit from a Wheelchair Accessible Vehicle? _____YES _____ NO Check All that Apply: _____ For safe community accessibility _____ For safe transportation of patient _____ Reduce risk of injury to patient and caregiver _____ Current method of Car Transportation is unsafe _____ Other options are unsafe	
ADDITIONAL RECOMMENDATION (if any):	
PHYSICIAN'S SIGNATURE:	**DATE:**
PHYSICIAN'S NAME:	**EMAIL:**
ADDRESS: **CITY:**	**STATE:** **ZIP:**
OFFICE #:	**FAX#:**

IF YOU AGREE YOUR PATIENT MEDICALLY NEEDS A WHEELCHAIR ACCESSIBLE VEHICLE, PROVIDE A MEDICAL PRESCRIPTION STATING "WHEELCHAIR ACCESSIBLE VEHICLE FOR" AND INDICATE YOUR PATIENT'S DIAGNOSIS. THANK YOU FOR YOUR TIME COMPLETING THIS FORM!

TEACHER'S RECOMMENDATION FORM

Mobility Angels Corporation is a 501 (c)(3) nonprofit organization dedicated to providing families with children who use a wheelchair independence and mobility. We are raising funds to provide eligible families a wheelchair accessible vehicle. All families should be able to travel to places, events, and activities away from their home; when they want to as well as when they need to. They should also be able to do it safely without injuring themselves or their child. Your student is applying for eligibility.

Thank you for your time completing this form and for your dedication to the children we serve!

CANDIDATE'S INFORMATION- Parent/Guardian please complete this section.			
STUDENT NAME:		**DATE OF BIRTH:**	
RESIDENTIAL ADDRESS:			
Apt/Unit:	**CITY:**	**STATE:**	**ZIP:**

TEACHER'S INFORMATION: The rest of the form is to be completed by Teacher.	
SCHOOL:	
SCHOOL ADDRESS:	
What grade is your student in?	What type of classroom?

Does your student use a wheelchair for mobility and positioning while at school?
_____ YES _____ NO

Check all that apply:

_____ Always uses a wheelchair
_____ Sometimes uses a wheelchair
_____ Uses School Bus Transportation
_____ Uses Adaptive Seating
_____ Is Able to help with transfers in/out of wheelchair to use bathroom
_____ Requires 2-person lift to be able to change soiled diaper
_____ Uses a Gait Trainer: Type: _____
_____ Receives School-Based Physical Therapy
_____ Receives School-Based Occupational Therapy

TEACHER'S NAME:	**EMAIL:**
TEACHER'S SIGNATURE:	**DATE:**

THERAPIST'S RECOMMENDATION FORM

Mobility Angels Corporation is a 501 (c)(3) nonprofit organization dedicated to providing families with children who use a wheelchair independence and mobility. We are raising funds to provide eligible families a Wheelchair Accessible Vehicle (WAV). All families should be able to travel to places, events, and activities away from their home; when they want to as well as when they need to. They should also be able to do it safely without injuring themselves or their child. Your patient is applying for eligibility.

CANDIDATE'S INFORMATION

PATIENT NAME:	**DATE OF BIRTH:**
DIAGNOSIS (Include ICD-10 Code/s):	

WHEELCHAIR FUNCTIONAL MOBILITY:

Does your patient use a wheelchair(WC) as a primary means for community mobility and positioning? _____ YES _____ NO

TYPE OF WC:	YEAR CURRENT WC PROVIDED:

Does the WC have Securement Transit Brackets installed? _____ YES _____ NO

What level of assistance does your patient need to maneuver WC?

Is your patient able to assist with locking/unlocking brakes? _____YES _____NO

Is your patient able to assist with removing/accomodating WC components such as foot rests and arm rests? _____YES _____NO

What level of a Assistance does you patient need to maneuver WC brakes, arm rests, foot rests? _____

Is your patient able to assist with stand-pivot or slide board transfers in/out of WC? _____NO

Type of Transfer: _____ _____YES

Level of Assistance: _____

AMBULATION FUNCTIONAL STATUS:

Is your patient able to stand? _____ NO _____ YES: Level of Assistance: _____

Is your patient able to Ambulate? _____NO ____YES: Distance:_____

Assistive Device for Gait Used, if any: _____

Level of Assistance for Gait: _____

Check All that Apply: _____ Community Ambulator _____Home Ambulator

ADDITIONAL FUNCTIONAL ASSESSMENT INFORMATION:

CURRENT CAR TRANSPORTATION STATUS:

Is the patient currently being lifted into the car/car seat? ____YES ____NO

Does initial lifting occur below waist level of caregiver? _____ YES _____NO

Does Turning/twisting occur during the transfer of patient from WC to car? ____YES ___NO

Does Bending occur during the transfer of patient from WC to car? ____YES ____NO

Does patient need to be held away from caregiver's body while transfering? ____YES ____NO

Does the patient have an Adaptive Car Seat? _____YES _____NO

Any Accessible Equipment in Vehicle currently available: ____NO ____YES

Describe:

Will the patient benefit from a Wheelchair Accessible Van? _____YES _____ NO

Check All that Apply: _____ For safe community accessibility

_____ For safe transportation of patient

_____ Reduce risk of injury to patient and caregiver

_____ Current method of Car Transportation is unsafe

_____ Other options are unsafe

THERAPIST NAME:	**EMAIL:**
License#:	

FACILITY NAME:

ADDRESS:

CITY: **STATE:** **ZIP:**

OFFICE #: **FAX#:**

Therapist's Signature:	DATE:

Note to Candidate's Physical and/or Occupational Therapist: A need's assessment will be conducted at the Wheelchair Accessible Vehicle vendor location. Further information may be needed from you and we will contact you for such information. Thank you for your time in completing this form and in the care you provide!