



Evaluation Form

Please fill out all items call 888-769-6084 if you have any questions

Patient Name

Height (No fractions)

Waist Circ (No fractions)

Height to elbow (No fractions)

Age

Weight

Thigh Circ (No fractions)

Activity Level (1 - 10)

Therapist Name

DME Provider

DME Phone

Therapist Email

DME ATP name

DME Email

Date of Evaluation

Special Comments

Check Desired Option

Pelvic support choices

- Easy Seat (W/ pelvic control)
- Pelvic cradle(Special order SWASH like attachment)

Torso support choices

- Chest Prompt Only
- Chest Prompt and shoulder straps
- Max Control Lateral
- No Torso support

Steering assist

- No Assist
- Guide Bar

Hand Prompts

- No Hand Prompts
- Adjustable Hand Prompts

Foot Positioning

- Anti Foot Drag
- Anti Scissor rails
- Anti Foot Drag and Anti scissor rails
- None

Color

- Blue
- Red

Fax to Sky Medical 954-747-3189 or Email to orders@skymedicalinc.com