

Center for Assistive Technology & Inclusive Education Studies (CATIES)
at The College of New Jersey

Information Form for Assistive Technology Evaluation: Physical Therapist

On _____
(date and time of appointment)

(client's name)

will participate in an assistive technology evaluation at the Center for Assistive Technology & Inclusive Education Studies (CATIES). Your input is very valuable to the evaluation. Please complete and return this form (to the address below or via fax 609-637-5179) no later than _____. Thank you for your assistance.

Seating / Positioning (Check all that apply):

- Sits in regular chair with feet on floor
- Sits in regular chair with support under feet
- Sits in adapted chair
- Sits in wheelchair

Desk Accessibility:

- Uses regular desk
- Uses desk with height adjusted
- Uses adapted table
- Uses wheelchair for desktop
- Has difficulty using table or desk

Description of Seating:

- Seating provides trunk stability
- Seating allows feet to be on the floor
- Seating provides 90/90/90 position
- Has difficulty with head control

Best position for head control is: _____

Summary of student's abilities and concerns related to seating and positioning:

Current fine motor abilities: Student has voluntary, isolated, controlled movements using

(Check all that apply) :

- | | | |
|---------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Left hand | <input type="checkbox"/> Right hand | <input type="checkbox"/> Eye(s) |
| <input type="checkbox"/> Left arm | <input type="checkbox"/> Right arm | <input type="checkbox"/> Head |
| <input type="checkbox"/> Left leg | <input type="checkbox"/> Right leg | <input type="checkbox"/> Mouth |
| <input type="checkbox"/> Left foot | <input type="checkbox"/> Right foot | <input type="checkbox"/> Tongue |
| <input type="checkbox"/> Finger(s) | <input type="checkbox"/> Eyebrows | |
| <input type="checkbox"/> Other: _____ | | |

Mobility (Check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Walks independently | <input type="checkbox"/> Uses manual wheelchair independently |
| <input type="checkbox"/> Walks with assistance | <input type="checkbox"/> Uses power wheelchair independently |
| <input type="checkbox"/> Walks with appliance | <input type="checkbox"/> Uses wheelchair for long distances only |
| <input type="checkbox"/> Has difficulty walking | <input type="checkbox"/> Uses elevator key independently |
| <input type="checkbox"/> Has difficulty walking up stairs | <input type="checkbox"/> Is pushed in manual wheelchair |
| <input type="checkbox"/> Has difficulty walking down stairs | <input type="checkbox"/> Learning to use power wheelchair |
| <input type="checkbox"/> Needs extra time to reach destination | <input type="checkbox"/> Needs help to transfer in and out of wheelchair |
| <input type="checkbox"/> Crawls, rolls, or creeps independently | <input type="checkbox"/> Transfers independently |

Concerns about mobility (Check all that apply):

- Student seems extremely tired after ambulating, requires a long time to recover
- Student seems to be having more difficulty than in the past
- Student complains about pain or discomfort
- Changes in schedule require more time to travel
- Changes in location or building are making it more challenging to get around
- Transition to new school will require consideration of mobility needs
- Other: _____

Summary of student's abilities and concerns related to mobility:

Range of motion: Student has specific limitations to range:

- Yes No

Describe the specific range in which the student has the most motor control:

Reflexes and muscle tone: Student has abnormal reflexes or abnormal muscle tone:

- Yes No

Describe briefly any abnormal reflex patterns or patterns of low or high muscle tone which may interfere with the student's voluntary motor control.

Reliable muscle groups:

Describe muscle groups the student can use consistently and accurately.

Name of person completing form: _____

Signature: _____

Date: _____

School / Program: _____

Please return by mail to: CATIES c/o Dept of Special Ed., Language & Literacy
PO Box 7718, Ewing, NJ 08628-0718

Or by fax to: (609) 637-5179