Home Assessment Evaluation Form

Patient's Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Type of Mobility Device

☐ Manual Wheelchair ☐ POV (Scooter) ☐ Power Wheelchair

Type of Home

☐ Single Story ☐ Multi Story ☐ Appt/Condo ☐ Mobile Home ☐ Assisted Living

Outside Access

☐ Ramp ☐ Threshold Ramp ☐ Elevator ☐ Stairs ☐ Other _____

Door / Hallway Measurements

Entry Door _____ inches Hallway _____ inches Bedroom _____ inches

Bathroom Door _____ inches Other Measurements _____

Are there any factors such as physical layout, floor surface, or obstacles that will render the mobility device unusable in the home? _____

_____

Does the patient's home provide adequate maneuvering space, access between rooms and between furniture for the mobility device? _____

_____

Supplier Assentation

I have completed the evaluation of the patient's home and conclude based upon this information the patient's home will accommodate the following mobility device.

☐ Manual Wheelchair ☐ POV (Scooter) ☐ Power Wheelchair

Comments: _____

_____

Date of Home Assessment _____

Supplier Signature _____ Date _____