Humana
Healthy Horizons®
in Louisiana

Humana Healthy Horizons® of Louisiana

Standing Frame Evaluation

Instructions:

1. PA-01 and Standing Frame Evaluation form are required with all requests.
2. Writing must be legible.
3. All sections must be completed by the professional listed and initialed. Enter N/A for items/sections that do not apply.
4. Please attach Physician prescription and original manufacturer price sheets.
   Glossary of terms is on the last page of form

I. GENERAL INFORMATION (PROVIDER): _____ Initials

Date of Evaluation: _____
Recipient Name: _____ DOB: _____
Recipient's Address: _____
Medicaid ID #: _____ Other Insurance: _____
Physician Name: _____ Therapist Name: _____

II. MEDICAL HISTORY (PHYSICIAN): _____ Initials

Diagnosis: _____
Age at diagnosis: _____ Prognosis: _____
Summary of medical condition:_____
_____
_____
_____
Describe any recent or expected changes in recipient's medical/physical/functional status:
_____
_____
_____
Estimated length of need for standing frame: _____

III. PRESENT STANDING FRAME (PROVIDER): _____ Initials

Does the recipient currently own any type of standing frame: ☐ Yes ☐ No
If yes, please provide the following information:
Serial #: _____ Age: _____
Model: _____ Size: _____
Price: _____ Funding Source: _____
Can the standing frame be repaired? ☐ Yes ☐ No
If yes, please explain.
_____
_____
_____
_____
_____

Why is the recipient's standing frame not meeting the recipient's needs:

_____
_____
_____
_____

IV. HOME ENVIRONMENT (PROVIDER/THERAPIST): _____ Initials

□ Home □ Apartment □ Mobile Home □ Asst. Living
□ Alone □ With family/caregivers
Is the caregiver available 24 hours a day? □ Yes □ No
If no, how many hours a day is the caregiver available? _____
Will the home environment accommodate the standing frame? □ Yes □ No
If no, will the home be modified? □ Yes □ No
Storage of standing frame: □ In home □ Other: _____
Comments: _____
_____
_____
_____

V. COGNITION (THERAPIST): _____ Initials

Memory	□ Intact	□ Impaired	Comments: _____
Problem Solving	□ Intact	□ Impaired	Comments: _____
Attn/Concentration	□ Intact	□ Impaired	Comments: _____
Vision	□ Intact	□ Impaired	Comments: _____
Hearing	□ Intact	□ Impaired	Comments: _____
Judgment	□ Intact	□ Impaired	Comments: _____

VI. COMMUNICATION (THERAPIST): _____ Initials

□ Verbal □ Non Verbal □ Sign Language □ Gestures □ Communication Device

VII. SENSATION (THERAPIST): _____ Initials

□ Intact □ Impaired □ Absent
History of pressure sores? □ Yes □ No
If yes, provide location and stage: _____
Current pressure sores? □ Yes □ No
If yes, provide location and stage: _____
Can the recipient perform pressure reliefs? □ Yes □ No
If yes, how: _____ If not, why: _____
Bowel management: □ Continent □ Incontinent
Bladder management: □ Continent □ Incontinent

VIII. PATHOLOGICAL REFLEXES (THERAPIST): _____ Initials

□ Asymmetrical tonic neck reflex □ Symmetrical tonic neck reflex □ Tonic labyrinthine reflex supine
□ Tonic labyrinthine reflex prone □ Extensor tone □ Startle □ Positive Supporting
□ Other: _____
Comments: _____
_____
_____

IX. MOBILITY (THERAPIST): _____ Initials

Transfers: □ Independent □ Mod I □ SPV □ Min A □ Mod A □ Max A □ Dependent

Method: □ Stand Pivot □ Squat Pivot □ Scoot Pivot □ Sliding Board □ Lift

Ambulatory status: □ Independent □ Mod I □ SPV □ Min A □ Mod A □ Max A □ Dependent

□ Non-ambulatory

If non-ambulatory, indicate the recipient's ambulatory potential:

□ Within 6 months □ Expected in 1 year □ Not expected

Distance: □ < 25 feet □ 25 – 50 feet □ 50- 100 feet □ 100-150 feet □ >150 feet

Device: □ Straight Cane □ Quad Cane □ Crutches □ Forearm Crutches □ Walker □ Gait Trainer

□ None □ Other: _____

Does the recipient own any of the following assistive devices? □ Yes □ No

□ Straight Cane □ Quad Cane □ Crutches □ Forearm Crutches □ Walker □ Gait Trainer

□ None □ Other: _____

Has the recipient tried walking with all ambulatory assistive devices? □ Yes □ No

Please explain why all the ambulatory assistive devices are not sufficient for the recipient's mobility. _____

_____

Does the recipient use a wheelchair as their primary mode of mobility? □ Yes □ No

X. STANDING FRAME PROGRAM/TRIAL & CONSIDERATIONS (THERAPIST/PROVIDER): _____ Initials

Please list the alternatives (ex: stretching, medications, serial casting, splinting, modalities and other standing frames) that were considered and rejected. Please include the make and model of alternatives tried as well as the length of trial with each alternative. _____

_____

_____

_____

_____

_____

Is the recipient in a standing program? □ Yes □ No

If yes, please explain the frequency, duration and tolerance. _____

_____

_____

_____

_____

_____

During the standing program did the recipient experience vertigo, nausea, orthostatic hypotension or tachycardia? □ Yes □ No

Are the caregivers willing and able to assist with the standing program? □ Yes □ No

Is the recipient willing to use the standing frame per the recommended home standing protocol? □ Yes □ No

Is the recipient able to operate the standing frame independently or with proper supervision? □ Yes □ No

Does the recommended standing frame have adequate support to position the recipient in a properly aligned standing position? □ Yes □ No

Were the caregivers trained in the use and maintenance of the standing frame? □ Yes □ No

Does the recipient have consistent access to the standing frame (transfer considerations and caregiver availability)? □ Yes □ No

Does the recommended standing frame allow for growth? □ Yes □ No

Does the recipient have sufficient access to a standing frame in another setting? □ Yes □ No
Does the recipient have a history of fractures or bone density issues? □ Yes □ No
Has the recipient tried the recommended standing frame and the therapist has witnessed the use of the system and recommends it? □ Yes □ No

XI. POSTURE (THERAPIST): (note if assessment done in sitting or supine) _____ Initials

Head Posture: □ WFL □ Flexed □ Extended □ Rotated □ Laterally flexed □ Cervical hyperextension
Head Control: □ Normal □ Good □ Fair □ Poor □ Absent
Trunk Posture: □ WFL □ Thoracic kyphosis □ Lumbar lordosis □ Scoliosis: left or right C or S curve
□ Rotation: left or right
Trunk Tone: □ Hypotonia □ Normal □ Hypertonia □ Spasticity □ Rigidity □ Athetosis □ Ataxia
□ Tremors
Severity: □ Mild □ Moderate □ Severe
Pelvis: □ Neutral □ Posterior □ Anterior □ Obliquity: left or right □ Rotation: left or right
□ Windswept: left or right □ Subluxation □ Dislocation □ Fracture

XII. UPPER EXTREMITY (THERAPIST): _____ Initials

LEFT			RIGHT	
AROM/PROM	STRENGTH (MMT)	UPPER EXTREMITY	STRENGTH (MMT)	AROM/PROM
	/5	Shoulder Flex	/5	
	/5	Shoulder Ext	/5	
	/5	Shoulder Abd	/5	
	/5	Shoulder Add	/5	
	/5	Elbow Flex	/5	
	/5	Elbow Ext	/5	
	/5	Wrist Flex	/5	
	/5	Wrist Ext	/5	
	Lbs.	Grip	Lbs.	

If unable to test the recipient's strength or ROM please explain why. _____
_____
_____

Shoulders:
□ WFL
□ Elevated/Depressed □ Fixed □ Partially flexible □ Flexible
□ Protracted/Retracted □ Fixed □ Partially flexible □ Flexible
□ Subluxed

Hands:
□ WFL □ Fisting □ Other: _____

UE Tone: □ Flaccid □ Hypotonia □ Normal □ Hypertonia □ Spasticity □ Rigidity
Comments on the recipient's UE: _____
_____
_____
_____
_____
_____

XIII. LOWER EXTREMITY (THERAPIST): _____ Initials

LEFT			RIGHT	
AROM/PROM	STRENGTH (MMT)	LOWER EXTREMITY	AROM/PROM	STRENGTH (MMT)
	/5	Hip Flex		/5
	/5	Hip Ext.		/5
	/5	Hip Abd		/5
	/5	Hip Add		/5
	/5	Hip IR		/5
	/5	Hip ER		/5
	/5	Knee Flex		/5
	/5	Knee Ext		/5
	/5	Ankle DF		/5
	/5	Ankle PF		/5
	/5	Ankle IV		/5
	/5	Ankle EV		/5

If unable to test the recipient's strength or ROM please explain why. _____
_____
_____
_____

Hip position:

☐ Neutral ☐ Hip Abduction ☐ Hip Adduction ☐ Subluxed ☐ Dislocated ☐ Leg length discrepancy
☐ Fixed ☐ Partially fixed ☐ Flexible

Windswept:

☐ Neutral ☐ Right ☐ Left
☐ Fixed ☐ Partially fixed ☐ Flexible

Does the recipient wear AFO's? ☐ Yes ☐ No

LE Tone: ☐ Flaccid ☐ Hypotonia ☐Normal ☐Hypertonia ☐ Spasticity ☐ Rigidity

Comments on recipient's LE: _____
_____
_____
_____

XIV. BALANCE (THERAPIST): _____ Initials

Sitting Balance:

Static: ☐ Normal ☐ Good ☐ Fair ☐Poor ☐Absent

Dynamic: ☐Normal ☐Good ☐Fair ☐Poor ☐Absent

Standing Balance:

Static: ☐ Normal ☐ Good ☐Fair ☐Poor ☐Absent

Dynamic: ☐ Normal ☐Good ☐Fair ☐Poor ☐Absent

Comments: _____
_____
_____
_____
_____
_____
_____

XV. PAIN AND EDEMA (THERAPIST): _____ Initials

Pain: ☐ Yes ☐ No

If yes, please state, severity (using the visual analog scale 0-10), location, and how often (daily, weekly, monthly). _____

_____

Is the recipient on pain medication? ☐ Yes ☐ No

If yes, please list medication. _____

Does pain medication alleviate the recipient's pain? _____

Edema: ☐ Yes ☐ No

If yes, please state severity, location, and how often (daily, weekly, monthly). _____

_____

Comments: _____

_____

_____

XVI. SEATING MEASUREMENTS (THERAPIST): (supine/sitting) _____ Initials

Height: _____ Weight: _____

Hip width: _____ Shoulder width: _____

Seat depth: _____ Top of shoulder: _____

Iliac crest: _____ Inferior angle of scapula: _____

Knee to heel: _____ Axilla: _____

Foot length: _____ Elbow: _____

Chest width: _____ Chest depth: ____

Top of head: _____

Does the recipient have a brace or orthosis? ☐ Yes ☐ No

If yes, please explain. _____

XVII. RECOMMENDED STANDING FRAME & NON-STANDARD PARTS (THERAPIST/PROVIDER): _____ Initials

1. Please provide the original manufacture price sheet.
2. Please describe the medical necessity for the requested equipment.
3. Please justify the standing frame size being recommended.
4. Medically justify each non-standard part on the standing frame.
5. List the standing frame parts in order of the manufacture price sheet.
6. Stamp signatures are not accepted.
7. The Provider can assist with all standing frame/part justifications.

Standing Frame Model: _____

Justification: _____

_____

_____

_____

Recommended standing program, include frequency and duration: _____

_____

_____

_____

Standing Frame size requested, how will this accommodate the recipient's current measurements: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Non-standard part on standing frame: _____
Justification: _____
_____
_____
_____

Therapist Signature:

I, _____ was present and participated in this evaluation, have personally completed this evaluation, and agree that the above standing frame and all the non-standard parts recommended are medically necessary for the above patient.

Physician Signature:

I, _____, have read this evaluation and agree that the above standing frame and all the non-standard parts recommended are medically necessary for the above patient.

_____
Therapist (Print Name)

_____ _____
Therapist's Signature/Credentials Date

_____
Physician (Print Name)

_____ _____
Physician's Signature/Credentials Date

_____
Provider (Print Name)

_____ _____
Provider's Signature/Credentials Date

Glossary of Terminology:

Abd – abduction
Add – adduction
AFO – ankle foot orthosis
AROM – active range of motion
Asst – assistive
Attn – attention
DF – dorsi-flexion
DOB – date of birth
ER – external rotation
EV – eversion
Ext – extension
Flex – flexion
IR – internal rotation
IV – inversion
Lbs – pounds
LE – lower extremity
Max A – maximal assistance
Min A – minimal assistance
MMT – manual muscle testing
Mod A – moderate assistance
Mod I – modified independent
N/A – not applicable
PF – planter-flexion
PROM – passive range of motion
ROM – range of motion
SPV – supervision
UE - upper extremity
WFL – within functional limits