1. Does the participant/subject use mobility devices?

[ ]  Yes (complete section 1)

[ ]  No

|  |
| --- |
| **Section 1. Mobility Devices** |
| Name of Device | Device Used? |
| Manual wheelchair | [ ]  Yes: [ ] Full-time use [ ] Part-time use[ ]  No[ ]  Not Applicable |
| Power wheelchair | [ ]  Yes: 1. [ ] Full-time use [ ] Part-time use
2. Is the wheelchair driven by the participant/subject? [ ]  Yes [ ]  No

[ ]  No[ ]  Not Applicable |
| Power assist wheelchair | [ ]  Yes: [ ] Full-time use [ ] Part-time use[ ]  No[ ]  Not Applicable |
| Other mobility device | [ ]  Yes (check all that apply)[ ]  Scooter [ ]  Stroller [ ]  Mobile standers [ ]  Standing wheelchairs [ ]  Other specify: [ ]  No[ ]  Not Applicable |

1. Does the participant/subject use lower extremity orthoses and assistive devices?

[ ]  Yes (complete section 2) [ ]  No

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| --- |
| **Section 2. Orthoses and Positioning Devices** |
| Name of Device | Device Used? |
| Shoe inserts of any type | [ ]  Yes[ ]  No[ ]  Not Applicable |
| Supramalleolar orthotic (SMO) | [ ]  Yes[ ]  No[ ]  Not Applicable |
| Ankle-foot orthosis (AFO) | [ ]  Yes: (check all that apply)1. Type: [ ]  Solid [ ]  Articulating [ ]  DAFO
2. Use: [ ]  Walking [ ]  Resting splints

[ ]  No[ ]  Not Applicable |
| Knee-ankle-foot orthosis (KAFO) | [ ]  Yes, ischial weight bearing? [ ]  Yes [ ]  No[ ]  No[ ]  Not Applicable |
| Hip-knee-ankle orthosis (HKAFO) | [ ]  Yes[ ]  No[ ]  Not Applicable |
| Reciprocal gait orthosis (RGO) | [ ]  Yes[ ]  No[ ]  Not Applicable |
| Stander | [ ]  Yes (check all that apply) [ ]  Supine [ ]  Prone [ ]  Static [ ]  Dynamic [ ]  Mobile[ ]  No[ ]  Not Applicable |
| Walker | [ ]  Yes (check all that apply) [ ]  Anterior [ ]  Posterior [ ]  Wheeled (circle) 2 4[ ]  No[ ]  Not Applicable |
| Crutches | [ ]  Yes (check all that apply) [ ]  Lofstrand [ ]  Forearm [ ]  Axillary [ ]  1 (circle) left right [ ]  2[ ]  No[ ]  Not Applicable |
| Cane | [ ]  Yes (check all that apply) [ ]  Single Point [ ]  Quad Base [ ]  1 (circle) left right [ ]  2[ ]  No[ ]  Not Applicable |
| Body jacket/ Thoracic-lumbar-sacral orthosis (TLSO) | [ ]  Yes[ ]  No[ ]  Not Applicable |
| Upper extremity assistive devices (ex: mobile arm support) | [ ]  Yes specify:[ ]  No[ ]  Not Applicable |
| Other Orthoses | [ ]  Other specify: |

|  |
| --- |
| **Section 3. Upper Extremity Orthoses** |
| Name of Device | Device Used? |
| Elbow orthosis | [ ]  Yes (check all that apply) [ ]  Night [ ]  Day [ ]  Static [ ]  Dynamic[ ]  No [ ]  Not Applicable |
| Wrist hand orthosis | [ ]  Yes (check all that apply) [ ]  Night [ ]  Day [ ]  Static [ ]  Dynamic[ ]  No [ ]  Not Applicable |
| Hand only | [ ]  Yes: (check all that apply) [ ]  Night [ ]  Day[ ]  No[ ]  Not Applicable |

1. Do you wear a body jacket/back brace /TLSO (check all that apply):

[ ]  No [ ]  Yes

If yes, [ ]  Night only [ ]  Day only [ ]  All the time

1. Do you use any other type of orthosis (Check all that apply):

[ ]  Neck [ ]  Hip [ ]  Shoulder

## **Assistive/Mobility Devices and Orthoses Instructions**

## General Instructions

This form contains data elements to track assistive and mobility devices used by the participant/subject.

## Specific Instructions

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.