FMA INITIAL DEMOGRAPHIC INTAKE

1. VGM Account Number: _____ 2. ATP RESNA Number: _____

3. Completed By: _____ 4. Patient Account Number: _____

5. Patient First Name: _____ 6. Patient Last Name: _____

7. First Three of Zip Code: _____ 8. Patient Year of Birth: _____

9. Height: _____(inches) 10. Weight: _____(pounds)

11. Body Mass Index (BMI) [Will Auto-Calculate] 12. Gender: ☐ a. Male ☐ b. Female ☐ c. Not Reported

13. Ethnicity: ☐ a. Black/African American ☐ b. American Indian or Alaska Native ☐ c. Asian
☐ d. White/Caucasian ☐ e. Native Hawaiian or Other Pacific Islander ☐ f. Hispanic/Latino
☐ g. Not Reported

14. Contact Phone: _____ 15. Email Address: _____

16. Date of Initial Evaluation: _____ 17. Date FMA Completed: _____

18a. Is this a Homelink Order? ☐ a. Yes ☐ b. No

18b. If yes, what is the Homelink Order #? _____

19. PRIMARY DIAGNOSIS:

☐ a. Amputation
☐ b. Amyotrophic Lateral Sclerosis/Primary Lateral Sclerosis
☐ c. Arthrogryposis
☐ d. Autism
☐ e. Cardiopulmonary Disease
☐ f. Cerebellar Degeneration
☐ g. Cerebral Palsy
☐ h. Developmental Delay
☐ i. Huntington Disease
☐ j. Morbid Obesity
☐ k. Mitochondrial Disorder
☐ l. Multiple Sclerosis
☐ m. Muscular Dystrophy
☐ n. Osteoarthritis
☐ o. Osteogenesis Imperfecta
☐ p. Post-Polio Syndrome
☐ q. Rheumatoid Arthritis
☐ r. SCI (Paraplegia)
☐ s. SCI (Tetraplegia/Quadriplegia)
☐ t. Seizure Disorder
☐ u. Spina Bifida
☐ v. Spinal Muscular Atrophy (SMA)
☐ w. Spinal Stenosis
☐ x. Spinocerebellar Disease
☐ y. Stroke/CVA
☐ z. Parkinson Disease
☐ aa. Traumatic Brain Injury (TBI)
☐ ab. Other Neuromuscular or Congenital Disease (Not Listed Above)

20. YEAR OF ONSET:

☐ a. _____ ☐ b. Unknown or Not Reported

21. DOES THE PERSON CURRENTLY HAVE SEATING-RELATED SKIN BREAKDOWN?

☐ a. Yes ☐ b. No ☐ c. Unsure

22. DOES THE PERSON HAVE HEALED SEATING-RELATED SKIN BREAKDOWN?

☐ a. Yes ☐ b. No ☐ c. Unsure

23a. HAS THE PERSON BEEN ADMITTED TO A HEALTHCARE FACILITY IN THE LAST 3 MONTHS? (I.E. IN-PATIENT, NURSING, OR REHABILITATION FACILITY)

☐ a. Yes ☐ b. No ☐ c. Unsure

23b. IF YES, WAS THE ENCOUNTER A RESULT OF A SEATING AND MOBILITY INCIDENT, SUCH AS A FALL OR SKIN BREAKDOWN?

☐ a. Yes ☐ b. No ☐ c. Unsure

24. HOW MANY TIMES HAS THE PERSON ACCIDENTALLY OR UNINTENTIONALLY FALLEN IN THE LAST 3 MONTHS?

☐ a. None ☐ b. 1-2 times ☐ c. 3-4 times ☐ d. 5 or more times ☐ e. Unknown

25. HOW MANY HOURS A DAY DOES THE PERSON REPORT THEY USE THE DEVICE IN THE LAST 3 MONTHS?

☐ a. 1 or Less ☐ b. 2-4 Hours ☐ c. 5-8 Hours ☐ d. 9-12 Hours ☐ e. 13+ Hours ☐ f. Unknown/No Device

26. HOW MANY TIMES A WEEK DOES THE PERSON REPORT THEY LEAVE THEIR HOME (NOT INCLUDING OUTINGS FOR MEDICAL APPOINTMENTS)?

☐ a. 1 or Less ☐ b. 2-3 Times ☐ c. 4-6 Times ☐ d. 7 or More Times ☐ e. Unknown

27. EMPLOYMENT:

☐ a. Employed/Student/Homemaker/Volunteer
☐ b. Not Employed/Not a Student
☐ c. Retired

28. LIVING SITUATION:

☐ a. Community – (i.e. home, apartment, condo)
☐ b. Assisted – (i.e. group home, assisted living)
☐ c. Skilled – (i.e. hospital, SNF, institution)
☐ d. Homeless

29. CURRENT MEANS OF TRANSPORTATION:

☐ a. Accessible Vehicle
☐ b. Inaccessible Vehicle
☐ c. Accessible Public Transportation (i.e. ACCESS, Paratransit)
☐ d. Accessible Vehicle for Hire (i.e. taxi, rental, delivery service)
☐ e. Ambulance/Medical Transport

30. CURRENT FUNDING:

☐ a. Medicare
☐ b. Medicare Managed Care
☐ c. Medicaid
☐ d. Medicaid Managed Care
☐ e. Vocational Rehab
☐ f. Private Insurance - Fee for Service
☐ g. Private Insurance – HMO
☐ h. Worker's Comp
☐ i. VA
☐ j. Private Pay
☐ k. Other/Not Listed

31. HAS THE PERSON'S DEVICE REQUIRED REPAIR SERVICE (I.E. IT STOPPED WORKING NEEDING SERVICE FROM THE SUPPLIER) BUT NOT INCLUDING ROUTINE MAINTENANCE (IE: BATTERY, TIRES, ARMPADS) IN THE LAST 3 MONTHS?

☐ a. Yes ☐ b. No ☐ c. Unsure

32. HAS THE PERSON'S DEVICE BEEN SERVICED FOR MAINTENANCE IN THE LAST 3 MONTHS (I.E. BATTERY, TIRES, ARMPADS)

☐ a. Yes ☐ b. No ☐ c. Unsure

33. CURRENT <u>PRIMARY</u> DEVICE:

☐ a. No Device
☐ b. Cane, Crutches, Walker
☐ c. Transport Wheelchair (attendant operated)
☐ d. K0001/K0002 Standard Manual Wheelchair
☐ e. K0003/K0004 Lightweight Manual Wheelchair
☐ f. K0005 Ultra Lightweight Manual Wheelchair
☐ g. K0006/K0007 Bariatric Wheelchair
☐ h. K0009 or Not Coded Manual Wheelchair
☐ i. Stroller
☐ j. Tilt-in-Space Manual Wheelchair
☐ k. POV/Scooter
☐ l. Group 1 Power Wheelchair
☐ m. Group 2 Power Wheelchair
☐ n. Group 3 Power Wheelchair
☐ o. Group 4 Power Wheelchair
☐ p. Group 5 Power Wheelchair
☐ q. Not Applicable/Not Listed

34. WAS AN ATP INVOLVED IN THE SELECTION AND FITTING OF CURRENT PRIMARY DEVICE?

☐ **a.** Yes ☐ **b.** No ☐ **c.** Unsure

35. AGE OF CURRENT EQUIPMENT:

☐ a. 1 Year or Less
☐ b. 2 Years
☐ c. 3 Years
☐ d. 4 Years
☐ e. 5 Years
☐ f. 6 Years
☐ g. 7 Years
☐ h. 8 Years
☐ i. 9 Years
☐ j. 10 Years or More
☐ k. Not Applicable

36. CURRENT EQUIPMENT MANUFACTURER:

☐ a. Amy Systems
☐ b. Colours
☐ c. Drive
☐ d. Etac/Snug Seat/R82/Convaid
☐ e. Freedom Designs
☐ f. Golden Technologies
☐ g. Hoveround
☐ h. Innovation in Motion
☐ i. Invacare
☐ j. Ki Mobility
☐ k. Levo
☐ l. Lifestand
☐ m. Merits/Avid Rehab
☐ n. Motion Composites
☐ o. Motion Concepts
☐ p. Panthera
☐ q. PDG
☐ r. Permobil
☐ s. Pride/Quantum
☐ t. Sunrise
☐ u. Ti Lite
☐ v. Unknown/Not Applicable/Not Listed

37. CURRENT DEVICE ACCESSORIES: (Check all that apply)

☐ a. Seat Elevator
☐ b. Tilt-in-Space
☐ c. Reclining Backrest
☐ d. Elevating Legrests
☐ e. Standing
☐ f. Anterior Tilt
☐ g. Power Assist for Manual Wheelchair
☐ h. Dynamic Seating Components
☐ i. No Accessory/Not Applicable

38. CURRENT CUSHION:

☐ a. Sling/Solid Seat
☐ b. Captain Seat
☐ c. General Use Cushion
☐ d. Skin Protection Cushion
☐ e. Positioning Cushion
☐ f. Combination – Protection and Positioning
☐ g. Custom Fabricated Cushion
☐ h. No Cushion/Not Applicable