

LOUISIANA TECH UNIVERSITY
CENTER FOR BIOMEDICAL ENGINEERING
AND REHABILITATION SCIENCE

History and Current Status Form

Please return this form to: Consumer Services Secretary
Louisiana Tech University
711 S. Vienna
Ruston, LA 71270
(318) 257-4562 (800) 310-4251

(To be completed by consumer's rehabilitation counselor, case worker, consumer or primary care giver)

_____, is being referred to the Center for Biomedical Engineering and Rehabilitation Science. Your input is needed in order to adequately assess this person's needs for adaptive equipment. We recognize the amount of time required to complete this form. However, the information will be valuable in determining the most appropriate recommendations for this individual. We appreciate your efforts in making this referral.

MEDICAL HISTORY

Primary Diagnosis: _____ Date of Onset _____

Other medical conditions: _____

Medications: _____

VOCATIONAL / ACADEMIC STATUS

Is the consumer currently employed? Yes ____ No ____

If yes, specify vocation / job title. _____

Is the consumer currently attending school? Yes ____ No ____

If yes, specify location and major / focus of study. _____

Other vocational or educational plans for the future: _____

CURRENT THERAPY

Therapist(s) and related personnel who work with this consumer:

<u>Name</u>	<u>Service</u>	<u>Frequency of Therapy/Treatment</u>	<u>Where to Contact</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

COGNITIVE/SOCIAL STATUS

Please indicate, if applicable, the person's level of intellectual functioning and the test(s) used to determine it:

<u>Test Name</u>	<u>Date</u>	<u>Results</u>	<u>Your Impression of Results</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MOBILITY STATUS

Is the consumer able to walk? Yes _____ No _____
If yes, please specify at what level: Independently _____ Walker _____ Cane _____ Crutches _____

What kind of equipment does she/he use? (Check all that apply)	<u>Home</u>	<u>School/Work</u>
manual wheelchair (make & model _____)	_____	_____
power wheelchair (make & model _____)	_____	_____
prone-stander	_____	_____
braces/crutches/canes	_____	_____
other _____	_____	_____

Is the consumer independent in propelling his/her wheelchair? Yes _____ No _____

Are there plans to replace current wheelchair in the next two years? Yes _____ No _____

If yes, specify model and type: _____

Is consumer able to transfer: between level surfaces? Yes _____ No _____ Unlevel surfaces? Yes _____ No _____

What adaptive equipment is used in transferring?
transfer board _____ pivot _____ lift system _____ Other _____

ACTIVITIES OF DAILY LIVING

Does the consumer require assistance with activities of daily living, i.e. dressing, bathing, feeding, grooming, toileting, etc.
Yes _____ No _____ If yes, with what activities? _____

Please specify hand dominance: Right hand _____ Left Hand _____

Does the consumer have difficulty communicating or expressing his or her needs? Yes _____ No _____
If yes, does he/she use an augmentative communication device (communication board, book, or electronic aid)?
Yes _____ No _____ If yes, describe the device _____

ADDITIONAL INFORMATION:

Indicate any specific questions or concerns you would like our evaluation team to address.

Please attach any other information you feel would be helpful to our evaluation.