Wheelchairs Plus

7719 Wurzbach Road
San Antonio, Texas 78229

SPECIAL NEEDS CAR SEAT MEDICAL NECESSITY FORM

Date:_____

Client Name:_____ D.O.B._____

Medicaid/Policy Number:_____

Height:_____ Weight:_____

Diagnosis:_____

Equipment requested:_____

_____

Client's functional level:_____

_____

Head control: ____ good ____ fair ____ poor ____ none
Trunk control: ____ good ____ fair ____ poor ____ none
UE control: ____ good ____ fair ____ poor ____ none
LE control: ____ good ____ fair ____ poor ____ none

Explanation of medical necessity of requested accessories:_____

_____

Length of time the equipment will be needed:_____

Growth potential of the equipment:_____

Manufacturer's make, model, pricing of equipment:_____

_____

Name of individual who will install the special needs car seat: Joel Garza, Certified Installer.

X_____

Therapists Signature