A Status Survey – Page 1

Master data for future care

To be completed by the therapist/physician/caregivers/patients together with the care provider

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Street address: _____

Post code: _____ City: _____

Parent/Guardian: Family name _____ Given name _____

Telephone: _____ E-Mail: _____

Cost bearer: _____ Phone: _____ Health insurance no: _____

Diagnoses:

Name and address of prescribing physician:

Name / type and address of institutions which the child attends:

Accompanying therapeutic measures / medications:

Physiotherapie: ❑ _____ Name: _____

Phone: _____ E-Mail: _____

Speech/language therapy: ❑ _____ Name: _____

Phone: _____ E-Mail: _____

Occupational therapy: ❑ _____ Name: _____

Phone: _____ E-Mail: _____

Other: ❑ _____ Name: _____

Phone: _____ E-Mail: _____

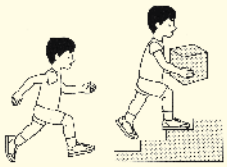
Which environmental and/or personal contextual factors have to be considered for the provision of aids?

❑ **Other annexes / therapy reports etc.**

Radiographs: ❑ **yes** ❑ **no**

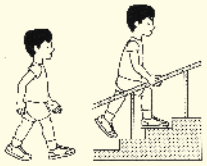
Body region 1 _____ Date _____ Body region 2 _____ Date _____

Classification of disability level according to GMFCS (GROSS MOTOR FUNCTION CLASSIFICATION SYSTEM)



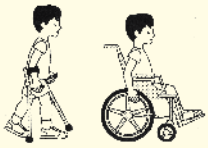
❑ **Level 1**

Children walk at home, school, outdoors and in the community. They can climb stairs without the use of railing. Children perform gross motor skills such as running and jumping, but speed, balance and coordination are limited.



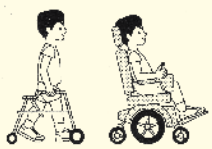
❑ **Level 2**

Children walk in most settings and climb stairs holding onto a railing. They may experience difficulty walking long distances and balancing on uneven terrain, inclines, in crowded areas or confined spaces. Children may walk with physical assistance, a handheld mobility device or use wheeled mobility over long distances. Children have only minimal ability to perform gross motor skills such as running and jumping.



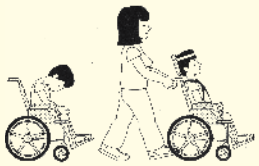
❑ **Level 3**

Children walk using a hand-held mobility device in most indoor settings. They may climb stairs holding onto a railing with supervision or assistance. Children use wheeled mobility when travelling long distances and may self-propel for shorter distances.



❑ **Level 4**

Children use methods of mobility that require physical assistance or powered mobility in most settings. They may walk for short distances at home with physical assistance or use powered mobility or a body support walker when positioned. At school, outdoors and in the community children are transported in a manual wheelchair or use powered mobility.



❑ **Level 5**

Children are transported in a manual wheelchair in all settings. Children are limited in their ability to maintain anigravity head and trunk postures and control leg and arm movements.

Body functions/structures and participation in activities according (to ICF)

BODY FUNCTIONS:	1	2	3	4	5
Mental functions					
Awareness					
Orientation					
Sensory functions and pain					
Seeing					
Hearing					
Sensation of pain					
Cardiovascular systems					
Cardiac function					
Respiratory function					
Digestive system functions					
Neuromuscular and movement-related factors					
Joint mobility:	1	2	3	4	5
Spine					
Shoulder					
Elbow					
Hand					
Hip					
Knee					
Foot					
Other					
Muscle tone					
Muscle strength					
Skin functions					
BODY STRUCTURES:					
Care-relevant structures:					

ACTIVITIES AND PARTICIPATION: (Assessment without the use of aids)	1	2	3	4	5
Learning and knowledge application					
General tasks and requirements					
Communication					
As receiver					
As transmitter (speaking/nonverbal)					
Mobility					
Change of body position					
Maintaining body position					
Sitting					
Standing					
Carrying/moving/handling objects					
Movement					
Rolling/crawling					
Walking					
Use of hands and arms					
Resting					
Grasping/reaching					
Self-sufficiency					
Personal hygiene					
Dressing/undressing					
Use of toilets					
Eating					
Other relevant data:					

1 without difficulty **2** little difficulty **3** moderate difficulty **4** great difficulty **5** impossible

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____
for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects. *The questionnaire is subject to the Social Data Protection, i.e. the disclosure of data to other persons/institutions is not permitted.*

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

_____

Unterschrift Datum

B Product-related Section

PG 10 Walking aids

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Outdoors ❑ Indoors

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

_____

_____

b) Dimensions: _____ _____

_____ _____

_____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 10)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

❑ Improvement of weight transfer to the legs	Goal achievement	❑ full	❑ partial	❑ none
❑ Strengthening of trunk and leg muscles	Goal achievement	❑ full	❑ partial	❑ none
❑ Prevention of secondary damage (Inactivity osteoporosis, joint malformations, soft part contractures)	Goal achievement	❑ full	❑ partial	❑ none
❑ Improvement of vital functions (cardiac circulation, respiration, digestion)	Goal achievement	❑ full	❑ partial	❑ none
❑ _____	Goal achievement	❑ full	❑ partial	❑ none

Activities and participation

❑ Providing opportunities for independent movement	Goal achievement	❑ full	❑ partial	❑ none
❑ Improvement of gait	Goal achievement	❑ full	❑ partial	❑ none
❑ Accident prevention when walking independently	Goal achievement	❑ full	❑ partial	❑ none
❑ Promotion of spatial orientation	Goal achievement	❑ full	❑ partial	❑ none
❑ Improvement of body coordination and control	Goal achievement	❑ full	❑ partial	❑ none
❑ Expansion of mobility range	Goal achievement	❑ full	❑ partial	❑ none
❑ _____	Goal achievement	❑ full	❑ partial	❑ none
❑ Other (individual SMART goals)	Goal achievement	❑ full	❑ partial	❑ none

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Anterior Walker	❑ available	❑ suitable	❑ needs improvement
❑ Posterior Walker	❑ available	❑ suitable	❑ needs improvement
❑ Walking trainer	❑ available	❑ suitable	❑ needs improvement
❑ Rail-guided walking trainer	❑ available	❑ suitable	❑ needs improvement
❑ Friction brake	❑ available	❑ suitable	❑ needs improvement
❑ Non-return device	❑ available	❑ suitable	❑ needs improvement
❑ Anti-tipper	❑ available	❑ suitable	❑ needs improvement
❑ Arm/forearm support	❑ available	❑ suitable	❑ needs improvement
❑ Gluteal pad	❑ available	❑ suitable	❑ needs improvement
❑ Hip pad/lateral guidance pad	❑ available	❑ suitable	❑ needs improvement
❑ Back pad	❑ available	❑ suitable	❑ needs improvement
❑ Breast pad ring	❑ available	❑ suitable	❑ needs improvement
❑ Headrest	❑ available	❑ suitable	❑ needs improvement
❑ Seat/saddle	❑ available	❑ suitable	❑ needs improvement
❑ Groin strap	❑ available	❑ suitable	❑ needs improvement
❑ Leg guide rail	❑ available	❑ suitable	❑ needs improvement
❑ Leg separator plate	❑ available	❑ suitable	❑ needs improvement
❑ Push handle	❑ available	❑ suitable	❑ needs improvement
❑ Transport tray/basket/table	❑ available	❑ suitable	❑ needs improvement
❑ Adjustable tilt angle	❑ available	❑ suitable	❑ needs improvement
❑ Four-point walking aid	❑ available	❑ suitable	❑ needs improvement
❑ Forearm walking aid	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

Remarks:

FAMILY NAME / GIVEN NAME OF CHILD:

7. Necessary Requirements (e.g. storage shelf for oxygen device)

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

_____

Signature Date

B Product-related Section

PG 11 Aids for preventing Decubitus

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Outdoors ❑ Indoors

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

4. Care-relevant Decubitus Risk of the Child

Risk assessment rehaKIND based on BVMed)

Please asses the decubitus risk on the basis of the
Risk assessment rehaKIND of children of 0 – 6 years
Risk assessment rehaKIND of children older than 6
Risk assessment of youths and young adults
(Download under www.rehakind.com.)

Total result Score nach Braden _____

The risk level is as follows:

Low risk ❑
Medium risk ❑
High Risk ❑

Specific features:

_____

_____

_____

_____

_____

_____

Weight: _____ kg Height: _____ cm

5. Care Provision Goals (PG 11)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Treatment of a pressure sore/pressure mark
- ❑ Prevention of pressure marks due to increased danger or previous pressure sores
- ❑ _____

Activities and participation

- ❑ Providing well-being/relaxation
- ❑ Support of pain therapy
- ❑ Improvement of sleeping situation
- ❑ Longer sitting times in order to take part in social life
- ❑ _____
- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Goal achievement ❑ full ❑ partial ❑ none

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Full-body position	❑ available	❑ suitable	❑ needs improvement
❑ Part-body position	❑ available	❑ suitable	❑ needs improvement
❑ Special seat cushion	❑ available	❑ suitable	❑ needs improvement
❑ Special back cushion	❑ available	❑ suitable	❑ needs improvement
❑ Pressure-relief support/mattress	❑ available	❑ suitable	❑ needs improvement
❑ Support for intermittent relief	❑ available	❑ suitable	❑ needs improvement
❑ Special effect mechanism (e.g. pressure relief, microstimulation Microstimulation) etc.)	❑ available	❑ suitable	❑ needs improvement
❑ Size of the bed surface	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

Instruction:
❑ made ❑ not made

Remarks:

FAMILY NAME / GIVEN NAME OF CHILD:

7. Necessary Requirements (e.g. storage shelf for oxygen device)

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

Signature Date

B Product-related Section

PG 15 Incontinence aids

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Other care

❑ Bladder malfunction ❑ Intestinal malfunction

Reason: _____

_____

_____

_____

***Initial care** = *Initial prescription of an aid of a special product type for specific care provision purposes*
***Repeated care** = *Repeated prescription of an already used aid (which has been outgrown or worn out)*
***Secondary care** = *Prescription of a second item of an already existing/similar aid*
***Other care** = *Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Outdoors ❑ Indoors

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

_____

_____

b) Specific features: _____

_____

Allergies: ❑ no ❑ yes: _____

_____

_____

Medication for treatment of bladder and intestinal malfunction? ❑ none

_____

_____

5. Care Provision Goals (PG 15)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

❑ Continence	Goal achievement	❑ full	❑ partial	❑ none
❑ Independent bladder and bowel emptying	Goal achievement	❑ full	❑ partial	❑ none
❑ Avoidance of skin damage	Goal achievement	❑ full	❑ partial	❑ none
❑ Avoidance of urinary tract infections	Goal achievement	❑ full	❑ partial	❑ none
❑ Avoidance of constipation / backflow of intestinal contents	Goal achievement	❑ full	❑ partial	❑ none
❑ _____	Goal achievement	❑ full	❑ partial	❑ none

Activities and participation

❑ Unrestricted (so far as possible) participation in family and social activities	Goal achievement	❑ full	❑ partial	❑ none
❑ _____	Goal achievement	❑ full	❑ partial	❑ none
❑ Other (individual SMART goals)	Goal achievement	❑ full	❑ partial	❑ none

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Disposable catheter	❑ available	❑ suitable	❑ needs improvement
❑ Condom urinal	❑ available	❑ suitable	❑ needs improvement
❑ Leg drainage bag	❑ available	❑ suitable	❑ needs improvement
❑ Anal plug, length _____	❑ available	❑ suitable	❑ needs improvement
❑ Anal irrigation	❑ available	❑ suitable	❑ needs improvement
❑ Absorbing supply	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

_____

_____

_____

_____

❑ Intermittent one-off catheterization	❑ available	❑ suitable	❑ needs improvement
❑ Self-catheterization ❑ external catheterization	❑ available	❑ suitable	❑ needs improvement
❑ How many times a day formatting _____	❑ available	❑ suitable	❑ needs improvement
❑ Condom urinal	❑ available	❑ suitable	❑ needs improvement
❑ Condom urinal, shaft length _____ cm, Ø _____ mm	❑ available	❑ suitable	❑ needs improvement
❑ Leg bag, volume _____ ml	❑ available	❑ suitable	❑ needs improvement
❑ Analtampon, Größe _____	❑ available	❑ suitable	❑ needs improvement
❑ Anal irrigation	❑ available	❑ suitable	❑ needs improvement
❑ Irrigation system, frequency check formatting of underline _____	❑ available	❑ suitable	❑ needs improvement
❑ Irrigation volume _____ ml	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Remarks:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY NAME / GIVEN NAME OF CHILD:

_____

7. Necessary Requirements

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

_____

Signature Date

B Product-related Section

PG 16 Aids for communication and information

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

3. Important Care-relevant Information on the Child

Existing communication of the child:

❑ Facial expression ❑ Gestures / hand signs ❑ Symbol board ❑ Free-flowing conversation

❑ speaking ❑ Gestures (e.g. DGS, GuK) ❑ Letter board ❑ Conversation with more words

❑ Spoken language ❑ Symbols ❑ Writing

Possible control:

❑ Direct control ❑ Scanning ❑ Mouse / Joystick

❑ Keyboard ❑ Eyes ❑ Super talker

4. Care Provision Goals (PG 16)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

1. Compensation for a physical impairment through appropriate control

- ❑ Direct control of aid (e.g. with finger guide, head mouse, eye control)
- ❑ Indirect control of aid (e.g. scanning)
- ❑ _____

2. Orientation in daily life and communication

- ❑ Orientation in space, among people, in time, action sequences, behavioural patterns (e.g. consequence plans)
- ❑ _____

3. Independent initiation of action or communication / creation of action plans

- ❑ Learning the principles of cause and effect as the basis of all communication
- ❑ Establishing relationships and dialogues (reciprocal action, turn-taking, involvement in group activities)
- ❑ _____

4. Increasing social contacts / participation/inclusion in the group

- ❑ talking about experiences (e.g. school day)
- ❑ Control actions (e.g. order sth. at the bakery)
- ❑ Executing tasks (take on tasks, make announcements, select classmates)
- ❑ _____

5. Selecting vocabulary/topics independently

- ❑ Specific selection (e.g. food, toys)
- ❑ Making multi-word statements, developing language learning (e.g. with single-word strategies)
- ❑ Complex communication using appropriately large vocabulary
- ❑ Learning written communication, developing written language acquisition
- ❑ _____

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Direct control of aid (e.g. with finger guide, head mouse, eye control)	Goal achievement	❑ full	❑ partial	❑ none
Indirect control of aid (e.g. scanning)	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
Orientation in space, among people, in time, action sequences, behavioural patterns (e.g. consequence plans)	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
Learning the principles of cause and effect as the basis of all communication	Goal achievement	❑ full	❑ partial	❑ none
Establishing relationships and dialogues (reciprocal action, turn-taking, involvement in group activities)	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
talking about experiences (e.g. school day)	Goal achievement	❑ full	❑ partial	❑ none
Control actions (e.g. order sth. at the bakery)	Goal achievement	❑ full	❑ partial	❑ none
Executing tasks (take on tasks, make announcements, select classmates)	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
Specific selection (e.g. food, toys)	Goal achievement	❑ full	❑ partial	❑ none
Making multi-word statements, developing language learning (e.g. with single-word strategies)	Goal achievement	❑ full	❑ partial	❑ none
Complex communication using appropriately large vocabulary	Goal achievement	❑ full	❑ partial	❑ none
Learning written communication, developing written language acquisition	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none

Remarks:

_____

_____

Signature:

_____
Parents / supervisor

_____
Responsible doctor / therapist

_____
Care provider Date

5. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

Device:

❑ Voice output	❑ available	❑ suitable	❑ needs improvement
❑ Writing input	❑ available	❑ suitable	❑ needs improvement
❑ Symbol input	❑ available	❑ suitable	❑ needs improvement
❑ Environmental control	❑ available	❑ suitable	❑ needs improvement
❑ Screen keyboard	❑ available	❑ suitable	❑ needs improvement
❑ Other keyboard:	❑ available	❑ suitable	❑ needs improvement

Vocabulary / content:

❑ Vocabulary strategy	❑ available	❑ suitable	❑ needs improvement
❑ Individual expansion of vocabulary	❑ available	❑ suitable	❑ needs improvement
❑ Grid structure (e.g. 3 x 3 boxes per page)	❑ available	❑ suitable	❑ needs improvement
❑ Free structure (e.g. with landscapes / photos)	❑ available	❑ suitable	❑ needs improvement
❑ Development of written language acquisition	❑ available	❑ suitable	❑ needs improvement

Accessory:

❑ Bracket (e.g. for wheelchair, table, rolling rack)	❑ available	❑ suitable	❑ needs improvement
❑ Bag	❑ available	❑ suitable	❑ needs improvement
❑ Carrier system	❑ available	❑ suitable	❑ needs improvement
❑ Sensors / buttons, external mouse etc.	❑ available	❑ suitable	❑ needs improvement
❑ Other:	❑ available	❑ suitable	❑ needs improvement

Remarks:

FAMILY NAME / GIVEN NAME OF CHILD:

6. Necessary Requirements

Reason:

7. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

_____

Signature Date

B Product-related Section

PG 18 Ambulance vehicles

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Outdoors ❑ Indoors

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

_____

_____

b) Dimensions: _____ _____

_____ _____

_____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 18)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Enabling a stable, safe and physiological sitting position
- ❑ Improved posture when seating
- ❑ Strengthening of arm and shoulder girdle muscles by independent movement
- ❑ Improvement of vital functions (cardiac circulation, respiration, digestion)
- ❑ _____

Activities and participation

- ❑ Providing opportunities for independent movement
- ❑ Promotion of independence in daily life
- ❑ Improvement of the visual orientation to discover the environment
- ❑ Safe transportation outside the home (e.g. visits to the doctor / clinics) check for double spaces
- ❑ Participation in organized social life within the family as well as other social communities and educational institutions
- ❑ Enlargement of the radius of life of parents and children through common activities
- ❑ Taking part in physical education within general compulsory education
- ❑ _____
- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Enabling a stable, safe and physiological sitting position	Goal achievement	❑ full	❑ partial	❑ none
Improved posture when seating	Goal achievement	❑ full	❑ partial	❑ none
Strengthening of arm and shoulder girdle muscles by independent movement	Goal achievement	❑ full	❑ partial	❑ none
Improvement of vital functions (cardiac circulation, respiration, digestion)	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
Providing opportunities for independent movement	Goal achievement	❑ full	❑ partial	❑ none
Promotion of independence in daily life	Goal achievement	❑ full	❑ partial	❑ none
Improvement of the visual orientation to discover the environment	Goal achievement	❑ full	❑ partial	❑ none
Safe transportation outside the home (e.g. visits to the doctor / clinics) check for double spaces	Goal achievement	❑ full	❑ partial	❑ none
Participation in organized social life within the family as well as other social communities and educational institutions	Goal achievement	❑ full	❑ partial	❑ none
Enlargement of the radius of life of parents and children through common activities	Goal achievement	❑ full	❑ partial	❑ none
Taking part in physical education within general compulsory education	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
Other (individual SMART goals)	Goal achievement	❑ full	❑ partial	❑ none

Remarks:

_____

_____

_____

Signature:

_____
Parents / supervisor

_____
Responsible doctor / therapist

_____
Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Adaptive wheelchair	❑ available	❑ suitable	❑ needs improvement
❑ Lap belt	❑ available	❑ suitable	❑ needs improvement
❑ Foot-fixing	❑ available	❑ suitable	❑ needs improvement
❑ Residual force supporting drive	❑ available	❑ suitable	❑ needs improvement
❑ One-hand drive	❑ available	❑ suitable	❑ needs improvement
❑ Push handles	❑ available	❑ suitable	❑ needs improvement
❑ Electric add-on drive	❑ available	❑ suitable	❑ needs improvement
❑ Push wheelchair for seating systems	❑ available	❑ suitable	❑ needs improvement
❑ Adjustable seat angle	❑ available	❑ suitable	❑ needs improvement
❑ Back angle adjustment	❑ available	❑ suitable	❑ needs improvement
❑ Manual wheelchair with standing function	❑ available	❑ suitable	❑ needs improvement
❑ Electric standing function	❑ available	❑ suitable	❑ needs improvement
❑ Electric wheelchair	❑ available	❑ suitable	❑ needs improvement
❑ Front-wheel drive	❑ available	❑ suitable	❑ needs improvement
❑ Middle-wheel drive	❑ available	❑ suitable	❑ needs improvement
❑ Back-wheel drive	❑ available	❑ suitable	❑ needs improvement
❑ Electric seat height adjustment	❑ available	❑ suitable	❑ needs improvement
❑ Electric seat floor adjustment	❑ available	❑ suitable	❑ needs improvement
❑ Electric adjustment of seat angle	❑ available	❑ suitable	❑ needs improvement
❑ Standing function	❑ available	❑ suitable	❑ needs improvement
❑ Electric adjustment of leg supports	❑ available	❑ suitable	❑ needs improvement
❑ Electric adjustment of backrest angle	❑ available	❑ suitable	❑ needs improvement
❑ Biometric back adjustment	❑ available	❑ suitable	❑ needs improvement
❑ Strength knots	❑ available	❑ suitable	❑ needs improvement
❑ Reha cart	❑ available	❑ suitable	❑ needs improvement
❑ Seat angle	❑ available	❑ suitable	❑ needs improvement
❑ Back angle adjustment	❑ available	❑ suitable	❑ needs improvement
❑ Torso-supporting pads	❑ available	❑ suitable	❑ needs improvement
❑ Positioning system	❑ available	❑ suitable	❑ needs improvement
❑ Rehabuggy	❑ available	❑ suitable	❑ needs improvement
❑ Preload bike (Handbike)	❑ available	❑ suitable	❑ needs improvement
❑ Side arm reduction	❑ available	❑ suitable	❑ needs improvement
❑ Adjustable crank	❑ available	❑ suitable	❑ needs improvement
❑ Automatic reverse gear	❑ available	❑ suitable	❑ needs improvement
❑ Elektric Drive	❑ available	❑ suitable	❑ needs improvement
❑ Wheelbase extension	❑ available	❑ suitable	❑ needs improvement
❑ Stair climbing aid	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

Remarks:

FAMILY NAME / GIVEN NAME OF CHILD:

Adjustment form is attached.

Please note:
Please refer to PG 22 for therapy wheels and bikes

7. Necessary Requirements (e.g. storage shelf for oxygen device)

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

Signature Date

B Product-related Section

PG 19 Nursing care products / handicapped accessible beds

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

** Initial care = Initial prescription of an aid of a special product type for specific care provision purposes*
** Repeated care = Repeated prescription of an already used aid (which has been outgrown or worn out)*
** Secondary care = Prescription of a second item of an already existing/similar aid*
** Other care = Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Outdoors ❑ Indoors

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

b) Dimensions: _____ _____

If you need a dimension sheet, you may download it under
www.rehakind.com

5. Care Provision Goals (PG19)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Improvement of vital functions (respiration etc.) through various lying and seating positions
- ❑ Reduction of sleep disturbance
- ❑ Prevention of secondary damage by appropriate positioning of the body
- ❑ _____

Activities and participation

- ❑ Enabling adequate care for the patient
- ❑ Improving the situation regarding basic care measures (catheterization, change of templates)
- ❑ Enabling safe, relaxed positioning without the risk of falling out of bed
- ❑ Enabling independent transfer (by height adjustment of the bed)
- ❑ _____
- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Height adjustment	❑ available	❑ suitable	❑ needs improvement
❑ manual			
❑ electric			
❑ Adjustable side grid	❑ available	❑ suitable	❑ needs improvement
❑ Adjustable bed surface	❑ available	❑ suitable	❑ needs improvement
❑ manual			
❑ electric			
❑ Bed shortener	❑ available	❑ suitable	❑ needs improvement
❑ Sitting-up aids	❑ available	❑ suitable	❑ needs improvement
❑ Fixing system	❑ available	❑ suitable	❑ needs improvement
❑ Bed protection inserts	❑ available	❑ suitable	❑ needs improvement
❑ Stand-up bed	❑ available	❑ suitable	❑ needs improvement
❑ Lateral position bed	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

Remarks:

FAMILY NAME / GIVEN NAME OF CHILD:

7. Necessary Requirements

Reasons:

8. Care Recommendation from the Care team:

Type: _____ HMV-No: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

Unterschrift Datum

B Product-related Section

PG 20 Positioning Aids

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

_____

_____

b) Dimensions: _____ _____

_____ _____

_____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 20)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Avoidance/prevention of secondary damage
- ❑ Post-operative improvement of joint mobility and joint stabilization
- ❑ Enabling a stable, safe and physiological position
- ❑ Enabling a pain-free position
- ❑ Influencing muscular tensions
- ❑ _____

Activities and participation

- ❑ Improving the active use of arms and hands
- ❑ Participating in family life and activities at the institution
- ❑ _____
- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Avoidance/prevention of secondary damage	Goal achievement	❑ full	❑ suitable	❑ none
Post-operative improvement of joint mobility and joint stabilization	Goal achievement	❑ full	❑ suitable	❑ none
Enabling a stable, safe and physiological position	Goal achievement	❑ full	❑ suitable	❑ none
Enabling a pain-free position	Goal achievement	❑ full	❑ suitable	❑ none
Influencing muscular tensions	Goal achievement	❑ full	❑ suitable	❑ none
	Goal achievement	❑ full	❑ suitable	❑ none
Improving the active use of arms and hands	Goal achievement	❑ full	❑ suitable	❑ none
Participating in family life and activities at the institution	Goal achievement	❑ full	❑ suitable	❑ none
	Goal achievement	❑ full	❑ suitable	❑ none
Other (individual SMART goals)	Goal achievement	❑ full	❑ suitable	❑ none

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

Requirements for the Equipment:

❑ Positioning system for children	❑ available	❑ suitable	❑ needs improvement
❑ Individually manufactured positioning shell	❑ available	❑ suitable	❑ needs improvement
❑ Positioning system with vacuum technology	❑ available	❑ suitable	❑ needs improvement
❑ Positioning rail for the following body parts:	❑ available	❑ suitable	❑ needs improvement

Description:

❑ Other	❑ available	❑ suitable	❑ needs improvement

Remarks:

FAMILY NAME / GIVEN NAME OF CHILD:

7. Necessary Requirements

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

_____

Signature Date

B Product-related Section

PG 22 Mobility Aids

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Boarding school, dormitory

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

_____

_____

b) Dimensions: _____ _____

_____ _____

_____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 22)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Improvement of body coordination
- ❑ Better joint mobility
- ❑ Improvement of vital functions (cardiac circulation, respiration, digestion)
- ❑ Strengthening of leg muscles
- ❑ Enabling different lying/seating positions
- ❑ Improvement of gait by alternating movements
- ❑ Respite for the carer / Prevention of damage to body functions and structures as a result of physical strain
- ❑ _____

Activities and participation

- ❑ Participation in family life/activities at the institution
- ❑ Social integration among peers
- ❑ Safe, preferably unrestricted movement/transportation
- ❑ Improvement of independent movement
- ❑ Better orientation/observation of the environment
- ❑ Facilitating transfer for activities relevant for daily life
- ❑ _____

- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Improvement of body coordination	Goal achievement	❑ full	❑ partial	❑ none
Better joint mobility	Goal achievement	❑ full	❑ partial	❑ none
Improvement of vital functions (cardiac circulation, respiration, digestion)	Goal achievement	❑ full	❑ partial	❑ none
Strengthening of leg muscles	Goal achievement	❑ full	❑ partial	❑ none
Enabling different lying/seating positions	Goal achievement	❑ full	❑ partial	❑ none
Improvement of gait by alternating movements	Goal achievement	❑ full	❑ partial	❑ none
Respite for the carer / Prevention of damage to body functions and structures as a result of physical strain	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
Participation in family life/activities at the institution	Goal achievement	❑ full	❑ partial	❑ none
Social integration among peers	Goal achievement	❑ full	❑ partial	❑ none
Safe, preferably unrestricted movement/transportation	Goal achievement	❑ full	❑ partial	❑ none
Improvement of independent movement	Goal achievement	❑ full	❑ partial	❑ none
Better orientation/observation of the environment	Goal achievement	❑ full	❑ partial	❑ none
Facilitating transfer for activities relevant for daily life	Goal achievement	❑ full	❑ partial	❑ none
_____	Goal achievement	❑ full	❑ partial	❑ none
Other (individual SMART goals)	Goal achievement	❑ full	❑ partial	❑ none

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Moving and lifting aids	❑ available	❑ suitable	❑ needs improvement
❑ Turntable	❑ available	❑ suitable	❑ needs improvement
❑ Position changing aids	❑ available	❑ suitable	❑ needs improvement
❑ Transfer/turning aid	❑ available	❑ suitable	❑ needs improvement
❑ Transfer board	❑ available	❑ suitable	❑ needs improvement
❑ Lifter	❑ available	❑ suitable	❑ needs improvement
❑ Foldable lifter	❑ available	❑ suitable	❑ needs improvement
❑ Required belts on the lifter:	❑ available	❑ suitable	❑ needs improvement

_____

_____

❑ Ramp systems	❑ available	❑ suitable	❑ needs improvement
❑ Telescopic ramp	❑ available	❑ suitable	❑ needs improvement
❑ Therapy wheel with support wheels	❑ available	❑ suitable	❑ needs improvement
❑ Tricyle	❑ available	❑ suitable	❑ needs improvement
❑ deep entry	❑ available	❑ suitable	❑ needs improvement
❑ Fixed sprocket	❑ available	❑ suitable	❑ needs improvement
❑ decouplable	❑ available	❑ suitable	❑ needs improvement
❑ Three-gear switch	❑ available	❑ suitable	❑ needs improvement
❑ Seven-gear switch	❑ available	❑ suitable	❑ needs improvement
❑ Special saddle shape	❑ available	❑ suitable	❑ needs improvement
❑ Back/pelvis pad	❑ available	❑ suitable	❑ needs improvement
❑ Push handles	❑ available	❑ suitable	❑ needs improvement
❑ steerable	❑ available	❑ suitable	❑ needs improvement
❑ Parking brake for accompanying person	❑ available	❑ suitable	❑ needs improvement
❑ Special handlebar shape:	❑ available	❑ suitable	❑ needs improvement

_____

❑ Foot supports	❑ available	❑ suitable	❑ needs improvement
❑ Crank shortener	❑ available	❑ suitable	❑ needs improvement
❑ Electric drive as power assistance	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

_____

_____

_____

_____

Remarks:

_____

_____

_____

_____

_____

_____

_____

_____

Please note:
For information on preload wheels/handbikes, please refer to PG 18

FAMILY NAME / GIVEN NAME OF CHILD:

_____

Adjustment form is attached.

7. Necessary Requirements (e.g. storage shelf for oxygen device)

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

_____

Signature Date

B Product-related Section

PG 23 Ortheses / Rails

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Areas of Application for Ortheses / Rails

❑ Positioning orthesis ❑ Functional orthesis ❑ Lying ❑ Sitting ❑ Standing ❑ Walking

Body parts: _____

_____

_____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations (type, date): _____

_____

_____

b) Specific medical therapy: _____

_____

_____

_____

5. Care Provision Goals (PG 23)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Correction/control of growth
- ❑ Avoidance/reduction of pain
- ❑ Relief of the spine when sitting
- ❑ Avoidance of secondary damage (contractures)
- ❑ Stabilization of one joint
- ❑ Stabilization of several joints
- ❑ Maintenance / support of the operation result
- ❑ Improvement of body perception and movement control through proprioceptive stimulation
- ❑ _____

Activities and participation

- ❑ Initiation of support for sitting
- ❑ Initiation of support for standing
- ❑ Initiation of support for walking
- ❑ Support of arm/hand/finger movement (grip function)
- ❑ _____
- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none
Goal achievement	❑ full	❑ partial	❑ none

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Functional Requirements for the Equipment

left	right	Functional Requirements	available / suitable / needs impro a.	s.	ni.
❑	❑	Toes	❑	❑	❑
❑	❑	Forefoot	❑	❑	❑
❑	❑	Hindfoot	❑	❑	❑
❑	❑	Lower ankle	❑	❑	❑
❑	❑	Upper ankle	❑	❑	❑
❑	❑	Lower leg	❑	❑	❑
❑	❑	Knee joint	❑	❑	❑
❑	❑	Upper leg	❑	❑	❑
❑	❑	Hip joint	❑	❑	❑
❑	❑	Pelvis	❑	❑	❑
❑	❑	Lumbar spine	❑	❑	❑
❑	❑	Thoracic spine	❑	❑	❑
❑	❑	Cervical spine	❑	❑	❑
❑	❑	Head	❑	❑	❑
❑	❑	Thumb	❑	❑	❑
❑	❑	Finger	❑	❑	❑
❑	❑	Middle hand	❑	❑	❑
❑	❑	Wrist joint	❑	❑	❑
❑	❑	Elbow joint	❑	❑	❑
❑	❑	Forearm	❑	❑	❑
❑	❑	Upper arm	❑	❑	❑
❑	❑	Shoulder joint	❑	❑	❑

Specific requirements e.g. for stabilization, range of movement, correcting effect and weight are, if applicable, to be described under the corresponding body regions. . Please furnish further particulars on constructive characteristics, single products etc. under point 8.

❑ **Separate remarks or reasons are attached as a separate annex.**

FAMILY NAME / GIVEN NAME OF CHILD:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

7. Necessary Requirements / Additions to the Functional Requirements under Point 6

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

_____

Signature Date

B Product-related Section

PG 26 Seating Aids

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Boarding school, dormitory

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

_____

_____

b) Dimensions: _____ _____

_____ _____

_____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 26)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Improving posture control of the torso and/or the head
- ❑ Prevention/stopping of secondary damage (deformities of bones and tendons)
- ❑ _____

Activities and participation

- ❑ Enabling safe, stable and physiological sitting
- ❑ Improving the active double space use of arm and hands
- ❑ Maintaining upright sitting for more than ___minutes__
- ❑ Improving/facilitating food intake
- ❑ Better spatial orientation and observation of the environment
- ❑ Enlargement of the radius of life of family and child
- ❑ Participation in family life and institutional activities
- ❑ Safe, preferably unrestricted transport inside/outside the home
- ❑ _____
- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Goal achievement ❑ full ❑ partial ❑ none

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

Seating system:

❑ Therapy chair	❑ available	❑ suitable	❑ needs improvement
❑ Pre-assembled seat shell	❑ available	❑ suitable	❑ needs improvement
❑ Individually assembled seat shell ❑ made to measure ❑ shape-printed	❑ available	❑ suitable	❑ needs improvement
❑ Dynamic seating system	❑ available	❑ suitable	❑ needs improvement
❑ Children's seating system for wheelchair	❑ available	❑ suitable	❑ needs improvement
❑ Car seat	❑ available	❑ suitable	❑ needs improvement
❑ Other:	❑ available	❑ suitable	❑ needs improvement

_____

_____

Accessories:

❑ Headrest	❑ available	❑ suitable	❑ needs improvement
❑ Pelvic and lumbar support	❑ available	❑ suitable	❑ needs improvement
❑ Anatomically shaped seat	❑ available	❑ suitable	❑ needs improvement
❑ Thoracic pads	❑ available	❑ suitable	❑ needs improvement
❑ Pelvic bracing	❑ available	❑ suitable	❑ needs improvement
❑ Footrest	❑ available	❑ suitable	❑ needs improvement
❑ Foot bracing	❑ available	❑ suitable	❑ needs improvement
❑ Abduction/adduction guide	❑ available	❑ suitable	❑ needs improvement
❑ Armrests	❑ available	❑ suitable	❑ needs improvement
❑ Therapy table	❑ available	❑ suitable	❑ needs improvement
❑ Upper arm guide	❑ available	❑ suitable	❑ needs improvement
❑ Upper body bracing	❑ available	❑ suitable	❑ needs improvement
❑ Other:	❑ available	❑ suitable	❑ needs improvement

_____

_____

Base frame:

❑ Vehicle chassis for indoor spaces	❑ available	❑ suitable	❑ needs improvement
❑ Vehicle chassis for outdoor areas	❑ available	❑ suitable	❑ needs improvement
❑ Vehicle chassis for indoor and outdoor use	❑ available	❑ suitable	❑ needs improvement
❑ Vehicle chassis with hand rims	❑ available	❑ suitable	❑ needs improvement
❑ Buggy /Reha cart frame	❑ available	❑ suitable	❑ needs improvement
❑ Adjustment of seat height (from _____ to_____)	❑ available	❑ suitable	❑ needs improvement
❑ Seat angle	❑ available	❑ suitable	❑ needs improvement
❑ Push handles	❑ available	❑ suitable	❑ needs improvement
❑ Other:	❑ available	❑ suitable	❑ needs improvement

_____

_____

Remarks:

_____

_____

_____

_____

_____

FAMILY NAME / GIVEN NAME OF CHILD:

_____

Adjustment form is attached.

7. Necessary Requirements

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

Signature Date

B Product-related Section

PG 28 Standing Aids

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

_____

_____

_____

_____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Boarding school, dormitory

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

_____

_____

_____

_____

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

_____

_____

b) Dimensions: _____ _____

_____ _____

_____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 28)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

❑ Improvement of weight transfer to both legs	Goal achievement	❑ full	❑ partial	❑ none
❑ Improvement of posture control	Goal achievement	❑ full	❑ partial	❑ none
❑ Activation of the lengthwise growth of bones	Goal achievement	❑ full	❑ partial	❑ none
❑ Prevention of secondary damage (contractures, inactivity osteoporosis, joint malformations)	Goal achievement	❑ full	❑ partial	❑ none
❑ Counteracting postural asymmetries and spinal deformities	Goal achievement	❑ full	❑ partial	❑ none
❑ Activation of vital functions	Goal achievement	❑ full	❑ partial	❑ none
	Goal achievement	❑ full	❑ partial	❑ none
❑ _____				
_____				
_____				

Activities and participation

❑ Enabling safe, stable and physiological standing	Goal achievement	❑ full	❑ partial	❑ none
❑ Improving active torso control	Goal achievement	❑ full	❑ partial	❑ none
❑ Improving head control	Goal achievement	❑ full	❑ partial	❑ none
❑ More independence through active movement while standing	Goal achievement	❑ full	❑ partial	❑ none
❑ Expansion of the radius of action	Goal achievement	❑ full	❑ partial	❑ none
❑ Better spatial orientation and observation	Goal achievement	❑ full	❑ partial	❑ none
❑ Enabling an age-appropriate perception level	Goal achievement	❑ full	❑ partial	❑ none
❑ Participation in family life and institutional activities	Goal achievement	❑ full	❑ partial	❑ none
	Goal achievement	❑ full	❑ partial	❑ none
❑ _____				
_____				
_____				

❑ Other (individual SMART goals)	Goal achievement	❑ full	❑ partial	❑ none

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Remarks:

_____
_____
_____

Signature:

_____
Parents / supervisor

_____
Responsible doctor / therapist

_____
Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Vertical standing device	❑ available	❑ suitable	❑ needs improvement
❑ Dynamic standing device	❑ available	❑ suitable	❑ needs improvement
❑ Prone board stander	❑ available	❑ suitable	❑ needs improvement
❑ Standing device from ventral position	❑ available	❑ suitable	❑ needs improvement
❑ Standing device from dorsal position	❑ available	❑ suitable	❑ needs improvement
❑ Seating/standing device	❑ available	❑ suitable	❑ needs improvement
❑ Standing driver	❑ available	❑ suitable	❑ needs improvement

Accessories:

❑ Gluteal pad	❑ available	❑ suitable	❑ needs improvement
❑ Pelvic pad	❑ available	❑ suitable	❑ needs improvement
❑ Spinal pad	❑ available	❑ suitable	❑ needs improvement
❑ Thoracic pad	❑ available	❑ suitable	❑ needs improvement
❑ Back pad	❑ available	❑ suitable	❑ needs improvement
❑ Chest pad	❑ available	❑ suitable	❑ needs improvement
❑ Knee pads	❑ available	❑ suitable	❑ needs improvement
❑ Individually adjustable in 3 levels	❑ available	❑ suitable	❑ needs improvement
❑ Anatomically shaped	❑ available	❑ suitable	❑ needs improvement
❑ Footplate	❑ available	❑ suitable	❑ needs improvement
❑ Height-/depth- and angle-adjustable	❑ available	❑ suitable	❑ needs improvement
❑ Footplate separated/individually height- / depth- and angle-adjustable	❑ available	❑ suitable	❑ needs improvement
❑ Foot shells	❑ available	❑ suitable	❑ needs improvement
❑ Foot fixing	❑ available	❑ suitable	❑ needs improvement
❑ Headrest	❑ available	❑ suitable	❑ needs improvement
❑ Electric angle adjustment	❑ available	❑ suitable	❑ needs improvement
❑ Electric seat belt retractor	❑ available	❑ suitable	❑ needs improvement
❑ Therapy table	❑ available	❑ suitable	❑ needs improvement
❑ Small transport wheels	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

Remarks:

FAMILY NAME / GIVEN NAME OF CHILD:

Adjustment form is attached

7. Necessary Requirements

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

Signature Date

B Product-related Section

PG 32 Therapeutic Movement Devices

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Boarding school, dormitory

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

b) Dimensions: _____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 32)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

- ❑ Improving the mobility of
  ❑ Legs ❑ Arms
- ❑ Preventing / stopping secondary damage (e.g. deformities of bones, tendons and muscles)
- ❑ Improving vital functions (cardiac circulation, respiration, digestion)
- ❑ Reduction in pathologic movement patterns
- ❑ Muscle strengthening
  ❑ Legs ❑ Arms
- ❑ Controlling muscle tension / tone
- ❑ _____

Activities and participation

- ❑ Improving opportunities for independent walking
- ❑ Improving possible actions with arms and hands
- ❑ _____

- ❑ Other (individual SMART goals)

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Goal achievement	❑ full	❑ partial	❑ none	Improving the mobility of ❑ Legs ❑ Arms
Goal achievement	❑ full	❑ partial	❑ none	Preventing / stopping secondary damage (e.g. deformities of bones, tendons and muscles)
Goal achievement	❑ full	❑ partial	❑ none	Improving vital functions (cardiac circulation, respiration, digestion)
Goal achievement	❑ full	❑ partial	❑ none	Reduction in pathologic movement patterns
Goal achievement	❑ full	❑ partial	❑ none	Muscle strengthening ❑ Legs ❑ Arms
Goal achievement	❑ full	❑ partial	❑ none	Controlling muscle tension / tone
Goal achievement	❑ full	❑ partial	❑ none	_____
Goal achievement	❑ full	❑ partial	❑ none	Improving opportunities for independent walking
Goal achievement	❑ full	❑ partial	❑ none	Improving possible actions with arms and hands
Goal achievement	❑ full	❑ partial	❑ none	_____
Goal achievement	❑ full	❑ partial	❑ none	Other (individual SMART goals)

Remarks:

Signature

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

Training device for the lower extremities with:

❑ Possibility for passive training / mobilization	❑ available	❑ suitable	❑ needs improvement
❑ Possibility for passive training with own muscle strength and motor support	❑ available	❑ suitable	❑ needs improvement
❑ Possibility for active training with own muscle strength and adjustable difficulty levels	❑ available	❑ suitable	❑ needs improvement

Training device for the lower extremities with:

❑ Possibility for arm training	❑ available	❑ suitable	❑ needs improvement
❑ Other	❑ available	❑ suitable	❑ needs improvement

Remarks:

FAMILY NAME / GIVEN NAME OF THE CHILD:

Testing report is attached.

7. Necessary Requirements

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

Signature Date

B Product-related Section

PG 04 Bathing Aids / PG 33 Toilet Aids

Additional information on prescription on _____ (Date)

Insured child: Family name _____ Given name _____

Date of birth: _____ Gender: ❑ Male ❑ Female

Cost bearer: _____ Health insurance no: _____

1. Reason for Care Provision*

❑ Initial care ❑ Repeated care ❑ Secondary care ❑ Other care

Reason: _____

* ***Initial care*** *= Initial prescription of an aid of a special product type for specific care provision purposes*
* ***Repeated care*** *= Repeated prescription of an already used aid (which has been outgrown or worn out)*
* ***Secondary care*** *= Prescription of a second item of an already existing/similar aid*
* ***Other care*** *= Prescription of another aid if the already existing one is not/no longer suitable for particular reasons*

2. Place / Area of Usage (multiple answers are possible)

❑ Family ❑ Institution ❑ Boarding school, dormitory

Particulars (e.g. high floor without elevator etc.): _____

3. Currently Existing Aid Provision (as far as relevant with regard to care provision)

4. Important Care-relevant Information on the Child

a) Definitively planned operations: _____

b) Dimensions: _____ _____

If you need a dimension sheet, you may download it under www.rehakind.com

5. Care Provision Goals (PG 04 / PG 33)

Please check off the intended goals with regard to function, activity and participation (ICF).
To state SMART reasons, please use the lines.
The physician/therapist should determine the goals collaboratively with the child/parents/caregivers.

Body function and structures

❑ Enabling a safe sitting and lying positions in the bath or shower	Goal achievement	❑ full	❑ partial	❑ none
❑ Enabling adequate body and skin care	Goal achievement	❑ full	❑ partial	❑ none
❑ Enabling a safe sitting position on the toilet (during excretions)	Goal achievement	❑ full	❑ partial	❑ none
❑ _____	Goal achievement	❑ full	❑ partial	❑ none

Activities and participation

❑ Easier emptying of the bladder/bowel	Goal achievement	❑ full	❑ partial	❑ none
❑ Facilitating independent body care	Goal achievement	❑ full	❑ partial	❑ none
❑ Developing possibilities of toilet training	Goal achievement	❑ full	❑ partial	❑ none
❑ Facilitating independent transfer to the bath/shower and toilet	Goal achievement	❑ full	❑ partial	❑ none
❑ Easier body care for the carer	Goal achievement	❑ full	❑ partial	❑ none
❑ _____	Goal achievement	❑ full	❑ partial	❑ none
❑ Other (individual SMART goals)	Goal achievement	❑ full	❑ partial	❑ none

Results check after 3-6 months of using the aid:

This part is to be completed by the doctor and/or the therapist together with the parents after 3-6 months of using the aid.
Please sign this section separately below.

Scheduled date for checkup: _____

Remarks:

Signature:

Parents / supervisor

Responsible doctor / therapist

Care provider Date

6. Equipment Requirements

Check on delivery

Please complete this part AT THE TIME OF DELIVERY.
The delivery also includes instructions for users/parents.

Date of delivery: _____

❑ Bathing stretcher	❑ available	❑ suitable	❑ needs improvement
❑ Bath seat	❑ available	❑ suitable	❑ needs improvement
❑ Shower aids	❑ available	❑ suitable	❑ needs improvement
❑ Shower stool	❑ available	❑ suitable	❑ needs improvement
❑ Shower chair/wheelchair	❑ available	❑ suitable	❑ needs improvement
❑ Shower stretcher	❑ available	❑ suitable	❑ needs improvement
❑ Toilet seat/chair	❑ available	❑ suitable	❑ needs improvement
❑ Bath lifter	❑ available	❑ suitable	❑ needs improvement
❑ Seat lifter	❑ available	❑ suitable	❑ needs improvement
❑ Stretcher lifter	❑ available	❑ suitable	❑ needs improvement
❑ Safety handle	❑ available	❑ suitable	❑ needs improvement

As aid for ❑ Shower ❑ Bath

Accessories:

❑ _____-time adapter for installation on the toilet	❑ available	❑ suitable	❑ needs improvement
❑ Chassis for driving to the toilet or the bath	❑ available	❑ suitable	❑ needs improvement
❑ Base frame for higher positioning in the bath	❑ available	❑ suitable	❑ needs improvement
❑ Footrest	❑ available	❑ suitable	❑ needs improvement
❑ Abduction guide	❑ available	❑ suitable	❑ needs improvement
❑ Seat reducer cushion	❑ available	❑ suitable	❑ needs improvement
❑ Pelvic belt	❑ available	❑ suitable	❑ needs improvement
❑ Chest belt	❑ available	❑ suitable	❑ needs improvement
❑ Thoracic pads	❑ available	❑ suitable	❑ needs improvement
❑ Other upper-body support	❑ available	❑ suitable	❑ needs improvement
❑ High backrest	❑ available	❑ suitable	❑ needs improvement
❑ Headrest	❑ available	❑ suitable	❑ needs improvement
❑ Possibility for height adjustment	❑ available	❑ suitable	❑ needs improvement
❑ Specially designed cushion parts	❑ available	❑ suitable	❑ needs improvement

_____

_____

❑ Other	❑ available	❑ suitable	❑ needs improvement

_____

_____

_____

_____

_____

_____

_____

Remarks:

_____

_____

_____

_____

_____

_____

_____

FAMILY NAME / GIVEN NAME OF CHILD:

_____

7. Necessary Requirements (e.g. stand-up bed/steep bed)

Reason:

8. Care Recommendation from the Care team:

Type: _____ HMV-No.: _____

Reason for use of individual product:

Signatures of the care team:

Family name	Signature	Date

Parent/Guardian: _____

Physician/Therapist: _____

Care provider: _____

I agree that (medical) data including photo documentation obtained for the child (given name): _____ for the purpose of an ideal aid provision are recorded for evaluation on a questionnaire. This questionnaire is used only by specialist medical staff as well as the aid provider (e.g. health care supply store) involved in the process. In the context of this care provision, I agree that these data may be forwarded to the health insurance provider if they are used for care provision purposes only. I am also aware that response to the questions is voluntary and that non-response will have no negative effects.

The questionnaire is subject to the social data protection.

Declaration of consent of parent(s) / guardian(s) / supervisor / other responsible parties

Signature Date