1. Does the participant use mobility devices?  Yes (complete section 1)  No
2. Does the participant use orthoses?  Yes (complete section 2)  No
3. Does the participant use positioning devices?  Yes (complete section 3)  No
4. Does the participant use ADL devices?  Yes (complete section 4)  No
5. Does the participant use transfer/transportation devices?

Yes (complete section 5)  No

1. Does the participant use communication devices?  Yes (complete section 6)  No

Table to Record Usages of External Devices

| Name of Device | Device Used? |
| --- | --- |
| Section 1. Mobility Devices | Intentionally left blank |
| Manual wheelchair | Yes – If yes,  Full-time  Part-time  Use distance –  Long distance  Short distance  Used at:  Home  School/Work  Community  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Propel –  Independent  Partial Independence  Dependent  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Power assist wheelchair | Yes – If yes,  Full-time  Part-time  Use distance –  Long distance  Short distance  Used at:  Home  School/Work  Community  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Propel –  Independent  Partial Independence  Dependent  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Power wheelchair | Yes – If yes,  Full-time  Part-time  Use distance –  Long distance  Short distance  Used at:  Home  School/Work  Community  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Propel –  Independent  Partial Independence  Dependent  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Scooter | Yes – If yes,  Full-time  Part-time  Use distance –  Long distance  Short distance  Used at:  Home  School/Work  Community  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Medical / Adaptive Stroller | Yes – If yes,  Full-time use  Part-time use  No |
| Walker | Yes – If yes,  Full-time use  Part-time use  Type of walker:  Reverse Rolling Walker  Front or Forward Walker (no wheels, two- wheeled, or four wheeled)  No |
| Gait Trainer / Weight Supported Walkers | Yes – If yes,  Full-time use  Part-time use  No |
| Crutches | Yes – If yes,  Full-time use  Part-time use  Type of crutches –  Lofstrand or Forearm Crutches  Bilateral  Unilateral  Underarm  Bilateral  Unilateral  Other, specify  No |
| Cane / Stick | Yes – If yes,  Single Point Cane  Bilateral  Unilateral  Quad Cane  Bilateral  Unilateral  No |
| Other mobility devices, specify: | Data to be entered by site |
| Section 2. Orthoses | Intentionally left blank |
| Shoe Inserts of any type | Yes – If yes,  Bilateral  Unilateral  No |
| Supramalleolar orthotic (SMO) | Yes – If yes,  Bilateral  Unilateral  No |
| Ankle-foot orthosis (AFO) | Yes – If yes:  Solid:  Bilateral  Unilateral  Articulating:  Bilateral  Unilateral  Dynamic Ankle Foot Orthosis (DAFO):  Bilateral  Unilateral  Posterior Leaf Spring (PLS):  Bilateral  Unilateral  Carbon Fiber:  Bilateral  Unilateral  No |
| Knee-ankle-foot orthosis (KAFO) | Yes – If yes,  Bilateral  Unilateral  No |
| Hip-knee-ankle foot orthosis (HKAFO) | Yes – If yes,  Bilateral  Unilateral  No |
| Dynamic Upper Extremity Orthosis/Splints | Yes – If yes,   |  |  | | --- | --- | | Left | Right | | Daytime use  Full-time use  Part-time use  Night time use | Daytime use  Full-time use  Part-time use  Night time use | | Anatomic Site:  Thumb  Wrist/hand  Hand/fingers  Elbow | Anatomic Site:  Thumb  Wrist/hand  Hand/fingers  Elbow |   No |
| Static Upper Extremity Orthosis/Splints | Yes – If yes,   |  |  | | --- | --- | | Left | Right | | Daytime use  Full-time use  Part-time use  Night time use | Daytime use  Full-time use  Part-time use  Night time use | | Anatomic Site:  Thumb  Wrist/hand  Hand/fingers  Elbow | Anatomic Site:  Thumb  Wrist/hand  Hand/fingers  Elbow |   No |
| Dynamic Lower Extremity Stretching Orthosis/Splints | Yes – If yes,   |  |  | | --- | --- | | Left | Right | | Daytime use  Full-time use  Part-time use  Night time use | Daytime use  Full-time use  Part-time use  Night time use | | Anatomic Site:  Ankle  Knee  Hip | Anatomic Site:  Ankle  Knee  Hip |   No |
| Static Lower Extremity Stretching Orthosis/Splints | Yes – If yes,   |  |  | | --- | --- | | Left | Right | | Daytime use  Full-time use  Part-time use  Night time use | Daytime use  Full-time use  Part-time use  Night time use | | Anatomic Site:  Ankle  Knee  Hip | Anatomic Site:  Ankle  Knee  Hip |   No |
| Other orthosis, specify: | Data to be entered by site |
| Section 3. Positioning Devices | Intentionally left blank |
| Seated or Lying Position Device | Yes – If yes:  Abduction wedge  Saddle seats/Bolster seats  Seat inserts  Corner chair  No |
| Stander | Yes – If yes:  Number of minutes per day\_\_\_\_\_  Number of days per week\_\_\_\_\_  No |
| Truncal Support Devices | Yes – If yes:  Neoprene trunk support  Thoracic-lumbar-sacral orthoses (TLSO)  Body jacket  Sitting Support Orthosis (SSO)  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Other, specify: |  |
| Section 4. ADL Devices | Intentionally left blank |
| Eating / Drinking Assistive Devices | Yes – If yes,  Cutlery / Chopsticks  Plates / Bowls  Cups, Mugs, Drinking Aids (e.g., Straws, grip adapters / attachments)  Stoppers and Funnels  Bib / Clothing Protectors  Feeding Systems (enteral / parenteral)  Feeding Apparatus (manual)  Food Guards  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Bathing Devices | Yes – If yes,  Bath chair/Bench  Roll-in shower  Removable shower head  Bathroom grab bars  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Toileting Devices | Yes – If yes,  Toilet chair/Commode  Toilet riser/Adaptive seat over toilet  Bathroom grab bars  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Other, specify |  |
| Section 5. Transfer/Transportation | Intentionally left blank |
| Transfer Devices | Yes – If yes,  Transfer bars  Transfer slings/belts  Transfer boards  Lift system (e.g., Hoyer, ceiling track system)  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Transportation Devices | Yes – If yes,  Adaptive car seat/Booster seat  Vehicle Lifts (e.g., Platform/Rotary)  Seating restraints (e.g., Manual, Electronic, Torso, Wheel Wells)  Vehicle with driver modifications  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Other, specify: |  |
| Section 6. Communication Devices | Intentionally left blank |
| Speaking Communication Device | Yes – If yes,  iPad  App used, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Android  App used, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dedicated Speech Generating Device (used for communication)  Specify device manufacturer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Specify device:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (e.g., Attainment GoTalk 20, Dynavox Maestro, PRC Accent 1000, Ablenet Step-by-Step)  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Non-Speaking Communication Device | Yes – If yes,  Communication Book or Board  Pictures/Picture Exchange Communication System (PECS)  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Access Communication Device | Yes – If yes,  Uses:  Finger  Eye gaze  Another body part, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Head or chin pointer  Brain-computer interface  One or more switches, device scans between messages  Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |
| Other, specify: |  |

## General Instructions

Information on the external devices used by the participant.

## Specific Instructions

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