1. Does the participant/subject use mobility devices?

Yes (complete section 1)

No

|  |  |
| --- | --- |
| **Section 1. Mobility Devices** | |
| Name of Device | Device Used? |
| Manual wheelchair | Yes: Full-time use Part-time use  No  Not Applicable |
| Power wheelchair | Yes:   1. Full-time use Part-time use 2. Is the wheelchair driven by the participant/subject?  Yes  No   No  Not Applicable |
| Power assist wheelchair | Yes: Full-time use Part-time use  No  Not Applicable |
| Other mobility device | Yes (check all that apply)  Scooter  Stroller  Mobile standers  Standing wheelchairs  Other specify:  No  Not Applicable |

1. Does the participant/subject use lower extremity orthoses and assistive devices?

Yes (complete section 2)  No

|  |  |
| --- | --- |
| **Section 2. Orthoses and Positioning Devices** | |
| Name of Device | Device Used? |
| Shoe inserts of any type | Yes  No  Not Applicable |
| Supramalleolar orthotic (SMO) | Yes  No  Not Applicable |
| Ankle-foot orthosis (AFO) | Yes: (check all that apply)   1. Type:  Solid  Articulating  DAFO 2. Use:  Walking  Resting splints   No  Not Applicable |
| Knee-ankle-foot orthosis (KAFO) | Yes, ischial weight bearing?  Yes  No  No  Not Applicable |
| Hip-knee-ankle orthosis (HKAFO) | Yes  No  Not Applicable |
| Reciprocal gait orthosis (RGO) | Yes  No  Not Applicable |
| Stander | Yes (check all that apply)  Supine  Prone  Static  Dynamic  Mobile  No  Not Applicable |
| Walker | Yes (check all that apply)  Anterior  Posterior  Wheeled (circle) 2 4  No  Not Applicable |
| Crutches | Yes (check all that apply)  Lofstrand  Forearm  Axillary  1 (circle) left right  2  No  Not Applicable |
| Cane | Yes (check all that apply)  Single Point  Quad Base  1 (circle) left right  2  No  Not Applicable |
| Body jacket/ Thoracic-lumbar-sacral orthosis (TLSO) | Yes  No  Not Applicable |
| Upper extremity assistive devices  (ex: mobile arm support) | Yes specify:  No  Not Applicable |
| Other Orthoses | Other specify: |

|  |  |
| --- | --- |
| **Section 3. Upper Extremity Orthoses** | |
| Name of Device | Device Used? |
| Elbow orthosis | Yes (check all that apply)  Night  Day  Static  Dynamic  No  Not Applicable |
| Wrist hand orthosis | Yes (check all that apply)  Night  Day  Static  Dynamic  No  Not Applicable |
| Hand only | Yes: (check all that apply)  Night  Day  No  Not Applicable |

1. Do you wear a body jacket/back brace /TLSO (check all that apply):

No  Yes

If yes,  Night only  Day only  All the time

1. Do you use any other type of orthosis (Check all that apply):

Neck  Hip  Shoulder

## **Assistive/Mobility Devices and Orthoses Instructions**

## General Instructions

This form contains data elements to track assistive and mobility devices used by the participant/subject.

## Specific Instructions

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