interco®
Aktivline!

Evaluation sheet

AKTIVLINE®

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Last name, First name _____

Date of birth (TT,MM,JJ) _____ Sex ☐ male ☐ female

Height _____ cm Weight _____ kg

School / Profession _____ Hobby / Sports _____

Date of first trial _____ Date of second trial _____

Diagnosis _____

Length of time seated per day ☐ < 1 hour ☐ 1 - 3 hours ☐ 3 - 5 hours ☐ 5 - 8 hours ☐ > 8 hours

without interruption: _____ hours

Length of time lying down per day ☐ < 1 hour ☐ 1 - 3 hours ☐ 3 - 5 hours ☐ 5 - 8 hours ☐ > 8 hours

without interruption: _____ hours

Length of time standing per day ☐ < 1 hour ☐ 1 - 3 hours ☐ 3 - 5 hours ☐ 5 - 8 hours ☐ > 8 hours

without interruption: _____ hours

Pain symptoms* _____

_____

☐ **mental and physical discomfort**

Pressure areas* _____

Neurovegetative dysfunction _____

Excretion / digestion ☐ Incontinence ☐ Obstipation

Drugs ☐ Muscle relaxants ☐ Antiepileptics

☐ Baclofen pump ☐ Botulinum Toxin*: _____

☐ Other*: _____

Important Surgery _____

☐ Selective dorsal rhizotomy

Skoliosis ☐ severe ☐ moderate ☐ mild ☐ correctable

☐ right convex ☐ left convex

☐ Hyperkyphosis (type)	☐ severe	☐ moderate	☐ mild	☐ correctable
☐ Hyperlordosis (type)	☐ severe	☐ moderate	☐ mild	☐ correctable
☐ Pelvic obliquity*	☐ severe	☐ moderate	☐ mild	☐ correctable
☐ Hip luxation (type)	☐ right	☐ left		
☐ Hip subluxation (type)	☐ right	☐ left		

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Flexibility

	rt. lt.		rt. lt.		rt. lt.	
Hip joint	☐ ☐	mobile	☐ ☐	constricted	☐ ☐	rigid
Knee joint	☐ ☐	mobile	☐ ☐	constricted	☐ ☐	rigid
Ankle joint	☐ ☐	mobile	☐ ☐	constricted	☐ ☐	rigid
Shoulder joint	☐ ☐	mobile	☐ ☐	constricted	☐ ☐	rigid

Remarks _____

_____

Hip joint (Following neutral measurement)	**Knee joint**	**Ankle joint**
Abd./Add. right ☐☐☐ left ☐☐☐ Flex/Ext. with knee extension ☐☐☐ / ☐☐☐ with knee extension with knee flexion / with knee flexion IR/AR ☐☐☐ ☐☐☐	Flex/Ext. right ☐☐☐ left ☐☐☐ with hip extension / with hip extension with hip flexion / with hip flexion Deformities:	PF/DE right ☐☐☐ left ☐☐☐ with knee extension / with knee extension with knee flexion / with knee flexion Deformities:

Progress of deformities is ☐ rapid ☐ slow

Difference in leg lengths (rt./lt.) Upper leg _____ cm Lower leg _____ cm

With **active** movement, the patient feels ☐ well ☐ the same ☐ poor

With **passive** movement, the patient feels ☐ well ☐ the same ☐ poor

Movement pattern*

☐ symmetrical ☐ asymmetrical ☐ in extension
☐ in flexion ☐ spastic ☐ dyskinetic
☐ chaotic ☐ with trunk torsion
☐ Other: _____

Affected parts of the body* ☐ All _____

(1 = mild
2 = severe
3 = very severe)

		rt. lt.		rt. lt.	
☐ Head	_____	☐ ☐ Shoulder	_____	☐ ☐ Arm	_____
☐ Trunk	_____	☐ ☐ Hand	_____	☐ ☐ Foot	_____
		☐ ☐ Hip	_____	☐ ☐ Knee	_____

Trigger*

☐ Excitement ☐ Strong stimuli* ☐ Change in position
☐ Speaking ☐ Pain ☐ Eating / Drinking
☐ Hand function ☐ Voluntary body movement
☐ Active control of the head ☐ Other: _____

Is any of the following treatments in use? ☐ Back brace* ☐ Orthotic device*

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Skin
☐ bruises easily ☐ poor blood circulation ☐ allergic reactions
☐ very sensitive ☐ mildly sensitive ☐ not sensitive

Eating
☐ independent ☐ with assistance ☐ with fixation
☐ with tube ☐ with stomach pump ☐ salivation
☐ reflux ☐ _____

Swallowing
☐ well ☐ difficult
Usual position when eating: _____

Breathing
☐ good ☐ limited ☐ poor
☐ Respiratory illnesses ☐ Diaphragm stimulator ☐ Breathing apparatus
☐ Secretion suction pump ☐ _____ ☐ _____

Communication
☐ not possible ☐ using a device ☐ non verbal ☐ verbal

Cognitive skills
☐ high ☐ moderate ☐ low

Head control	☐ good	☐ moderate	☐ low	☐ none at all
Hand motor function	☐ good	☐ moderate	☐ low	☐ none at all
Eye/hand coordination	☐ good	☐ moderate	☐ low	☐ none at all

Sight	☐ good	☐ limited	☐ blind	☐ Devices: _____
Hearing	☐ good	☐ limited	☐ deaf	☐ Devices: _____

Environmental control
☐ independent
☐ delegated
☐ Devices: _____

Therapies
☐ Physiotherapy ☐ Occupational therapy ☐ Speech therapy

Treatment to date
☐ Active wheelchair ☐ Standard seat shell ☐ Buggy
☐ Electric wheelchair ☐ Seat shell ☐ none

Satisfaction
☐ very satisfied ☐ somewhat satisfied ☐ dissatisfied

Reason
_____
_____

Duration of treatment to date from _____ to _____

Description of the posture system
☐ very satisfied ☐ somewhat satisfied ☐ dissatisfied

Features for
☐ Residential environment ☐ Kindergarten ☐ School
☐ Outdoors ☐ Workplace ☐ Transport
☐ _____

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Fixation
☐ Trunk ☐ Pelvis ☐ Arms
☐ Legs ☐ Head ☐ Feet
☐ _____

Head rest
☐ shell-shaped ☐ half-roll ☐ with occipitoparietal support
☐ with wings ☐ lat. positioned ☐ dynamic
☐ _____

Back rest
☐ Standard ☐ based on custom contour ☐ with anat. lateral side supports
☐ immersible ☐ lat. supports ☐ with table

Seat
☐ Standard ☐ Special cushions ☐ anat. shaped
☐ based on custom contour ☐ Abduction pommel ☐ Ischial relief insert
☐ Add. guide ☐ _____

Leg rest
☐ Standard ☐ complete ☐ with individual foot rests
☐ adjustable ☐ custom-built ☐ Foot guide
☐ _____

Undercarriage
☐ Street undercarriage ☐ Room undercarriage ☐ Wheelchair
☐ Electric wheelchair ☐ Wheelchair with auxiliary electric motor

Control _____

Transfer
☐ independent ☐ with assistance ☐ with 1-2 persons ☐ Lifter

Trial with an AKTIVLINE
☐ Trial with demo AKTIVLINE no.: _____ ☐ with feedforward hydraulic brake

Shell suspension	☐ hard	☐ moderate	☐ soft	
Leg rest system suspension	☐ hard	☐ moderate	☐ soft	
Movement start in AKTIVLINE	☐ slow	☐ fast		
Movement end in AKTIVLINE	☐ slow	☐ fast		
Movement pattern	☐ symmetrical	☐ asymmetrical		
Frequency of extension	☐ rare	☐ often	Duration: _____	Sek.

Location
☐ All ☐ Head ☐ Shoulder ☐ Arm
☐ Trunk ☐ Hip ☐ Knee ☐ Foot

Radius of movement
☐ minimal ☐ moderate ☐ up to the stop

Acceptance of the AKTIVLINE during trial
☐ good ☐ poor ☐ unclear

Duration of first trial _____ ☐ another trial being considered

Results of the trial / consultation

☐ Design of a rigid seat shell ☐ Design of a dynamic seat shell
☐ Design of an initial treatment ☐ Design of a second treatment
☐ Design of a development-related modification ☐ combined with electric wheelchair

in regular use at: ☐ Kindergarten ☐ School / Work ☐ Nursing Home ☐ At home

☐ Stair climbers and/or push aids are required ☐ Transportation option is required

☐ special environmental conditions are to be observed: _____

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Treatment objective with new treatment according to quote:

- ☐ Prevention of damage due to immobility
- ☐ Relief of pain
- ☐ Relief of decubitus
- ☐ Improving posture control (head, trunk, pelvis)
- ☐ Improving breathing function
- ☐ Improving joint mobility
- ☐ Improving bowel function
- ☐ Improving hand function
- ☐ Improving psychomotility

☐ Other: _____

_____

Reason:

Participating persons in the trial and consultation:

Physician	_____	Date / Signature	_____
Therapist	_____	Date / Signature	_____
Caregiver	_____	Date / Signature	_____
Parents	_____	Date / Signature	_____
Medical device advisor	_____	Date / Signature	_____

Documentation of the trial available by means of ☐ Video ☐ Digital photos

Declaration of informed consent

I / we hereby consent to allow the detailed documentation of this trial by means of video and/or digital photos.

_____ _____

Date Signature of the legal guardian

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