WELLNESS CENTER AT RANCHO
Indego Program
THERAPY PARTICIPATION FORM

Dear therapist,
Your patient, _____, would like to participate in Wellness Center at Rancho Indego Training Program.
In order to participate, the following is **absolute criteria** (please place "x" next to all necessary criteria):
__Physical Therapy Evaluate and Treat order/Ordering Physician name:_____/Date of order:_____
__SCI level C7 or lower
__Height 5' 1: (155 cm) to 6' 3" (195 cm)
__Weight under 250 lbs (113 kg)
__Leg length discrepancy no greater than 0.5" (1.27 cm)
__Cannot be "high" fracture risk, according to "Risk Factors for Lower Extremity Low-Trauma Fracture After SCI"
__Tolerates fully upright standing position without dizziness or other symptoms for 15 minutes
__Skin intact where it interfaces with the device
__Sufficient upper extremity strength to utilize the device and any necessary aids (at least 4/5 in one proximal upper extremity)
Relative criteria (exceptions may be made based off of clinical judgement, or referred to physician if unsure)
__Full passive ROM of lower extremities
__Modified Ashworth Spasticity level 3 or less
__Functional use of at least one upper extremity
__"Moderate" fracture risk, according to "Risk Factors for Lower Extremity Low-Trauma Fracture After SCI," is appropriate as long education of risk of fracture is provided, and patient has not had a fracture in the last 2 years

Does the patient have any **absolute contraindications**? If yes, patient is not eligible for use of Ekso Indego device:
__Cognitive impairments or psychiatric conditions that may result in inability to follow directions
__Heterotopic ossification
__Unstable blood pressure in standing position or presence of orthostatic hypotension
__Lower limb prosthesis
__Unstable vital signs
__Unhealed truncal, pelvic, and/or lower extremity fractures
__Unresolved deep vein thrombosis
__Uncontrolled autonomic dysreflexia
__Severe cardiopulmonary disease
__Presence of lower extremity contractures
__"High" fracture risk, according to "Risk Factors for Lower Extremity Low-Trauma Fracture After SCI"
Are there any **relative contraindications** present? (exceptions may be made based off of clinical judgement, or cosult with physician if unsure)
__Presence of other severe comorbid neurological injuries (MS,CP, motor neuron disease, brain injury, etc.)
__Less than 4/5 strength in either upper extremity

TO BE COMPLETED BY PARTICIPANT
I, _____, authorize my healthcare provider to release the following requested information to Rancho Los Amigos National Rehabilitation Center and to the Rancho Research Institute, Inc. for the purpose of participating in the "Wellness Center at Rancho"

_____	_____	_____	_____
Signature of Participant	Date	Signature of Guardian or Parent if a Minor	Date

TO BE COMPLETED BY PHYSICAL THERAPIST (Initial the appropriate line below):
Patient has limitations and is **not cleared** to participate. _____ (PT initials)
Patient is **cleared** for the contraindications listed above and may participate in the Wellness Center at Rancho Indego Program with these conditions:
Patient has **no limitations** to participation. _____ (PT initials)
Patient has **limitations to participation**, however if patient adheres to these limitations, s/he is cleared to participate, limitations are as follows:_____
_____ (PT initials)

_____	_____	_____	_____
Physical Therapist's Name (Please print)	**Phone Number**	**Physical Therapist's Signature**	**Date**