

Patient Name:

Appointment Date:

Practitioner:

Fax:

Total Pages: 6



## ***Practitioner's 3 Easy Steps for the visit:***

**1.  Complete the**

Face-to-Face form\* and the Prescription form during the exam

**2.  Document in the chart note**

that a mobility evaluation occurred (if a mobility exam occurred during the appointment)

**3.  Fax**

- The Face to Face Examination Form
- The Prescription Form
- The Chart Notes

to

If you have questions please call

(888) 344-2181

Confirmation of the prescription will follow.

\*Practitioner has the choice on how to document the need for PMD; simply complete the attached form, download the form yourself for completion, or address all of the form questions in the patient's chart note.

**Date of Evaluation:** \_\_\_\_\_

<b>Patient Information</b>				
Name:		HICN:		
Mailing Address:		Telephone: (    )		
City:	State:	ZIP:	DOB:	Age:      Gender:    M    F
<b>Physician or Treating Practitioner Information</b>				
Name:		NPI:		
Mailing Address:		Telephone: (    )		
City:		State:		ZIP:
<b>Current Symptoms, Related Diagnosis, and History</b> (Must be completed by physician or treating practitioner)				
1. What medical conditions/diseases limit your patient's mobility in their home?				
<input type="checkbox"/> CHF	<input type="checkbox"/> COPD	<input type="checkbox"/> CVA	<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Diabetes/Neuropathy
<input type="checkbox"/> Hemiparesis	<input type="checkbox"/> Hemiplegia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Paraparesis	<input type="checkbox"/> Paraplegia	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Other, please describe: _____				
2. Symptoms				
<input type="checkbox"/> Abnormal Gait	<input type="checkbox"/> Amputation	<input type="checkbox"/> Cardiac Arrhythmias	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Intermittent Claudication	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Orthostasis	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Syncope	<input type="checkbox"/> Tremor	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Walking Limitations	<input type="checkbox"/> Weakness
<input type="checkbox"/> Other, please describe: _____				
3. Pain Location				
<input type="checkbox"/> Head	<input type="checkbox"/> Face	<input type="checkbox"/> Neck	<input type="checkbox"/> Chest	<input type="checkbox"/> Abdomen
<input type="checkbox"/> Pelvis/Groin	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Sacrum	<input type="checkbox"/> R/L Shoulder
<input type="checkbox"/> R/L Arm	<input type="checkbox"/> R/L Elbow	<input type="checkbox"/> R/L Wrist/Hand	<input type="checkbox"/> R/L Hip/Thigh	<input type="checkbox"/> R/L Knee
<input type="checkbox"/> R/L Ankle/Foot	<input type="checkbox"/> Other, please describe: _____			
<b>Physical Exam</b> (Must be completed by physician or treating practitioner)				
Ht:	Wt:	B/P:	Pulse (resting):	Pulse (exertion):
Shortness of Breath at Rest? Y / N	Shortness of Breath w/Exertion? Y / N	Is O <sub>2</sub> Required? Y / N	Number of Liters?	O <sub>2</sub> Sats?
Current Pressure Sores? Y / N	History of Pressure Sores? Y / N	Locations?	Stage?	Able to Shift Weight? Y / N
Poor Balance? Y / N	Poor Endurance? Y / N	History of Falls? Y / N	Risk of Falls? Y / N	Significant Edema? Y / N

Patient's Name: \_\_\_\_\_

<b>Medications</b> (List all medications the patient is currently taking relating to the need of a power mobility device)		
Medication	Date Started	Dosage

<b>History of Present Problem</b>			
<b>1. Functional Ambulatory Limitations</b> (Complete all limitations that apply)			
Gait/Walk Pattern	<input type="checkbox"/> Normal	<input type="checkbox"/> Ataxic	<input type="checkbox"/> Shuffling
	<input type="checkbox"/> Mod. Assist	<input type="checkbox"/> Max. Assist	<input type="checkbox"/> Non-Ambulatory
Limitation	Onset	Description	Diagnosis
Balance/History or Risk of Falls			
Fatigue/Weakness			
Inability to Ambulate			
Other: _____			
<b>2. Physical Limitations</b> (Check all limitations that apply and describe all non-normal findings)			
Upper Body Weakness	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate (Describe) _____	<input type="checkbox"/> Severe (Describe) _____
Upper Body Pain	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate (Describe) _____	<input type="checkbox"/> Severe (Describe) _____
Upper Body Range of Motion	<input type="checkbox"/> Normal	<input type="checkbox"/> Partially Limited (Describe) _____	<input type="checkbox"/> Severely Limited (Describe) _____
Lower Body Weakness	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate (Describe) _____	<input type="checkbox"/> Severe (Describe) _____
Lower Body Pain	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate (Describe) _____	<input type="checkbox"/> Severe (Describe) _____
Lower Body Range of Motion	<input type="checkbox"/> Normal	<input type="checkbox"/> Partially Limited (Describe) _____	<input type="checkbox"/> Severely Limited (Describe) _____

Patient's Name: \_\_\_\_\_

**Ambulatory Status in Relation to Mobility Related Activities of Daily Living (MRADL) in Home**

1. Without a mobility aid, how far can the patient safely walk without stopping? \_\_\_\_\_ ft.  
Does this distance allow the patient to independently accomplish **ALL** MRADL in the home in a safe and timely fashion?  
 Yes     No    If No, please describe: \_\_\_\_\_  
(e.g., required significant rest, risk of falling, can only do once per day, etc.)
2. Please select all MRADL that your patient is unable to accomplish in the home in a safe and timely fashion due to mobility limitations.  
 Feeding     Bathing     Grooming     Dressing     Toileting     Other: \_\_\_\_\_
3. Does the patient have the ability to stand from a seated position without assistance?  
 Yes     No    If No, please describe transferring options the patient could use: \_\_\_\_\_  
\_\_\_\_\_

**Mobility Determination Questions**

1. Can a cane or walker meet this patient's mobility needs to independently accomplish **ALL** mobility related activities of daily living (MRADL) in the home in a safe and timely fashion?  
 Yes     No    If No, describe the condition and/or diagnosis related to the safe and timely completion of their MRADL:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Can a manual wheelchair meet this patient's mobility needs to independently accomplish **ALL** MRADL in the home in a safe and timely fashion?  
 Yes     No    If No, describe the condition and/or diagnosis related to the safe and timely completion of their MRADL:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. How has your patient's condition/functional limitations changed so that they now require a power mobility device to complete their MRADL inside the home?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Name: \_\_\_\_\_

**Mobility Determination Questions (cont'd)**

4. In order to qualify for a power wheelchair, you must consider and rule out a power operated vehicle/scooter.

Some of the limitations of the power operated vehicle/scooter or reasons a patient would not be able to use a power operated vehicle/scooter are listed below. Check all applicable limitations or conditions.

- Patient requires elevating leg rest (ELR)

Examples of limitations/conditions include:

- Patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee
- Patient has significant edema of lower extremities that requires having an elevated leg rest
- Patient meets criteria for and has reclining back on wheelchair

- Patient requires fully reclining back seat

Examples of limitations/conditions include:

- Patient has a risk for development of a pressure ulcer and is unable to perform a functional weight shift
- Patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed
- Patient's home presents insufficient space for maneuvering power operated vehicle/scooter

- Patient requires adjustable height armrests

Examples of limitations/conditions include:

- Patient requires an arm height that is different than that available using nonadjustable arms
- Patient spends at least 2 hours per day in the wheelchair

- Patient is unable to safely operate power operated vehicle/scooter

- Patient presents poor trunk stability
- Patient needs special seat cushion for skin protection

- Patient requires joystick controller

- Patient cannot operate handlebar controller

- Other: \_\_\_\_\_

- None of the above limitations apply. Therefore the patient may not qualify for a power wheelchair, however the patient may qualify for a power operated vehicle/scooter.

5. Does the patient have the physical and mental abilities to safely operate a power mobility device in their home?

Yes  No If No, describe why:

\_\_\_\_\_

6. Is your patient willing and motivated to use power mobility equipment in their home?

Yes  No If No, describe what findings support that the patient is not motivated to operate a power mobility device in the home:

\_\_\_\_\_

- Based on this face-to-face evaluation, the patient has functional limitations that support the need for a **standard power mobility device** and does not require further evaluation.
- Based on this face-to-face evaluation, the patient has functional limitations that support the need for a **complex rehabilitation power mobility device** but a specialty evaluation is required. (A specialty Seating/Mobility Evaluation will be scheduled and a follow-up assessment completed within the next 45 days.)
- Based on this face-to-face evaluation, the patient **does not** have functional limitations that support the need for a power mobility device and does not require further evaluation.

I certify that the information provided is a true and accurate representation of my patient's current condition and that a major reason for the visit was a mobility examination. I hereby incorporate this document into my patient's medical record.

**Physician or Treating Practitioner**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Power Mobility Device - 7 Element Order  
PRESCRIPTION**

1. Beneficiary/Patient Name:



\_\_\_\_\_

2. Item for Order:



\_\_\_\_\_

3. Date of Face to Face Examination:



\_\_\_\_\_

4. Diagnosis/Condition Relating to the need for Item:



**ICD-9 Code**

**Diagnosis**

ICD-9 Code	Diagnosis
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____
_____ . _____	_____

5. Length of Need (LON):



\_\_\_\_\_

*(99=lifetime)*

6. Physician's Signature:



\_\_\_\_\_

(No Signature Stamps)

7. Date:



\_\_\_\_\_

**Please fax back to:**