

Date of Evaluation: _____

Patient Information				
Name:		HICN:		
Mailing Address:		Telephone: ()		
City:	State:	ZIP:	DOB:	Age: Gender: M F
Physician or Treating Practitioner Information				
Name:		NPI:		
Mailing Address:		Telephone: ()		
City:		State:		ZIP:
Current Symptoms, Related Diagnosis, and History (Must be completed by physician or treating practitioner)				
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: _____				
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: _____				
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: _____			
Physical Exam				
Ht:	Wt:	B/P:	Pulse (resting):	Pulse (exertion):
Shortness of Breath at Rest? Y / N	Shortness of Breath w/Exertion? Y / N	Is O ₂ Required? Y / N	Number of Liters?	O ₂ 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: _____

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

History of Present Problem

Functional Ambulatory Limitations (Complete all limitations that apply)			
Gait/Walk Pattern	<input type="checkbox"/> Normal <input type="checkbox"/> Mod. Assist	<input type="checkbox"/> Ataxic <input type="checkbox"/> Max. Assist	<input type="checkbox"/> Shuffling <input type="checkbox"/> Non-Ambulatory
Limitation	Onset	Description	Diagnosis
Balance/History or Risk of Falls			
Fatigue/Weakness			
Inability to Ambulate			
Other: _____			

Physical Limitations (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) _____

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.)

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: _____

Patient's Name: _____

Current Mobility Related Activities for Daily Living (MRADL) Status in Home

MRADL	Independent	Needs Some Assistance	Needs Total Assistance	Independent w/Equipment	Not Assessed	Comments/Equipment Needed
Dressing						
Eating						
Grooming/ Hygiene						
Toileting						
Bathing						
Other: _____						

Check one: Continent Incontinent Accidents

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 such that they now require a power mobility device to complete their ADL 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; or
- Patient has significant edema of lower extremities that requires having an elevated leg rest; or
- Patient meets criteria for and has reclining back on wheelchair

Patient requires adjustable height armrests

Examples of limitations/conditions include:

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

Patient requires joystick controller

Patient cannot operate handlebar steering device

Other: _____

Patient requires manual 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; or
- 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 is unable to safely operate power operated vehicle/scooter

Patient presents poor trunk stability

Patient needs special seat cushion for skin protection

If you check this box, none of the limitations listed above apply and the patient may qualify for a power operated vehicle/scooter, thereby excluding a power wheelchair.

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 device 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 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 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: _____