Mobility Assistive Equipment – Face to Face Examination Report

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: ____

Address: _____ City: _____ State: ____ Zip: _____

Primary Insurance: Secondary Insurance: SSN: Tel:

PHYSICIAN INFORMATION OR TREATING PRACTITION INFORMATION

Doctors Name: _____ Date of Last Visit: _____

Address: _____ City / State / Zip:_____

UPIN #: NPI #: Medicaid #: Tel:

CURRENT SYMPTOMS, RELATED DIAGNOSES, AND HISTORY

Please describe the reason for this mobility evaluation

_____

_____

_____

Please list previously diagnosed conditions that relate to the current office visit

_____

_____

_____

PHYSICAL EXAM

Ht:	Wt:	B/P:	Pulse (resting):	Respiratory: Normal Labored at times Is O2 required **Y** ☐ **N** ☐
Any Current pressure sores? **Y** ☐ **N** ☐ Location:				
Poor Balance: **Y** ☐ **N** ☐		History or Risk of Falls: **Y** ☐ **N** ☐		Poor Endurance: **Y** ☐ **N** ☐
Cachexia (severe weakness): **Y** ☐ **N** ☐		Obesity: **Y** ☐ **N** ☐		Significant Edema: **Y** ☐ **N** ☐
Holds to furniture/walls for mobility: **Y** ☐ **N** ☐				
Neck, Trunk and Pelvis Posture and Flexibility: Good ☐		Limited ☐		Severely Limited ☐

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FUNCTIONAL ASSESMENT

Question	You Answers below must be justified by your narrative responses	
1. Does your patient have a mobility limitation that impairs participation in Mobility required Activities of Dally Living (MRADLs) in the home? If YES, why:_____ _____	☐ YES ☐ NO	GO TO QUESTION **2** STOP – NO MAE
2. Can their limitations be compensated by the addition of MAE to improve the ability to participate in MRADLs in the home? If YES, why:_____ _____	☐ YES ☐ NO	GO TO QUESTION **3** STOP – NO MAE
3. Is your patient or their caregiver capable and willing to operate the MAE safety in the home?	☐ YES ☐ NO	GO TO QUESTION **4** STOP – NO MAE
4. Can their mobility deficit be safety resolved by a cane or walker? If NO, why:_____ _____	☐ YES ☐ NO	STOP – ORDER CANE OR WALKER GO TO QUESTION **5**
5. Dos your patient's home environment support use of a wheelchair or POV? (Home assessment to be completed by Medical Equipment Supplier)	☐ YES ☐ NO	GO TO QUESTION **6** STOP – NO MAE
6. Does your patient have the upper extremity function to safely propel a manual wheelchair to participate in MRADLs in the home? If NO, why:_____ _____	☐ YES ☐ NO	STOP – ORDER MANUAL WHEELCHAIR GO TO QUESTION **7**
7. Does your patient have sufficient strengths and trunk stability to operate a POV in the home? Please Explain:_____ _____	☐ YES ☐ NO	GO TO QUESTION **8** GO TO QUESTION **9**
8. Is your patient able to safely maneuver a POV in the Home?	☐ YES ☐ NO	STOP – ORDER POV GO TO QUESTION **9**
9. Does your patient need the additional features (i.e. optimal maneuverability of use, upgradeable/adaptable seating, etc.) Of power wheelchair to participate in MRADLs in the home? If Yes, why: _____ _____	☐ YES ☐ NO	GO TO QUESTION **10** STOP – NO MAE
10. Is your patient safe and able to maneuver wheelchair in the home?	☐ YES ☐ NO	STOP – ORDER PWC STOP

The Information provided is a true and accurate representation of my patient's current condition. I hereby incorporate this document into my patient's medical record. This document is supported by additional medical records in my patient's file.

Physician or Treating Practitioner Signature: **Date:**