

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 PRACTITIONER 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 <input type="checkbox"/>	N <input type="checkbox"/>
Any Current pressure sores? Y <input type="checkbox"/> N <input type="checkbox"/> Location: _____						
Poor Balance: Y <input type="checkbox"/> N <input type="checkbox"/>		History or Risk of Falls: Y <input type="checkbox"/> N <input type="checkbox"/>		Poor Endurance: Y <input type="checkbox"/> N <input type="checkbox"/>		
Cachexia (severe weakness): Y <input type="checkbox"/> N <input type="checkbox"/>		Obesity: Y <input type="checkbox"/> N <input type="checkbox"/>		Significant Edema: Y <input type="checkbox"/> N <input type="checkbox"/>		
Holds to furniture/walls for mobility: Y <input type="checkbox"/> N <input type="checkbox"/>						
Neck, Trunk and Pelvis Posture and Flexibility:			Good	Limited	Severely Limited	

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FUNCTIONAL ASSESSMENT

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: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> 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: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO	GO TO QUESTION 4 STOP – NO MAE
4. Can their mobility deficit be safety resolved by a cane or walker? If NO, why: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> 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)	<input type="checkbox"/> YES <input type="checkbox"/> 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: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> 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: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	GO TO QUESTION 8 GO TO QUESTION 9
8. Is your patient able to safely maneuver a POV in the Home?	<input type="checkbox"/> YES <input type="checkbox"/> 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: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	GO TO QUESTION 10 STOP – NO MAE
10. Is your patient safe and able to maneuver wheelchair in the home?	<input type="checkbox"/> YES <input type="checkbox"/> 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: