7 Element Order

A physician may only write a prescription must contain the following seven elements:

1-Beneficiary's name

2-Description of the item that is to be ordered. This may be general e.g, "power operated vehicle(POV)," "power wheelchair," or "power mobility device" - or may be more specific.

3-Date Of completion or the face-to-face examination

4.peainent diasno'is/conditions that relate to the need for the POV or power wheelchair

5-length Of need

6-Physician's signature and date

7-Physician's NPI Number

The order needs to be filled out in the physician's hand writing throughout the order.

Must have Progress Notes & Chart Notes

Patient Name:	Physician Name:
Address:	Location:
Phone#:	Phone#:
DOB:	
Height:	Weight:

Date of face to face: _____

Requested Durable Medical Equipment:	
Diagnosis Code (ICD-10)(Must have code and name spelled out):	
Length of Time Equipment Needed (Must be spelled out):	
Physician Signature:	**Signature Date:**
Physician NPI#:	

Mobility Assistive Equipment - Face to Face Examination Report

Patient Information:					
Name					**Medicare (HICN)#:**
Mailing Address:					**Telephone:**
City:	**State:**	**Zip:**	**DOB:**	**Age:**	**SSN:**
Physician or Treating Practitioner Information					
Name					**Date of last visit:**
Mailing Address:					**Telephone:**
City:		**State:**			**Zip:**

Current Symptoms Related Diagnoses and History
Please describe the reason for this mobility evalution
Please list previously diagnosed conditions that relate to the current office visit

Physical Exam				
Ht:	**Wt:**	**B/P:**	**Pluse (resting):**	**Respiratory** ○ **Normal** ○ **Labored at times** **Is O_2 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 (servere weakness): ○ **Y** ○ **N**		**Obesity:** ○ **Y** ○ **N**		**Significant Edema:** ○ **Y** ○ **N**
Holds to furniture/walls for mobility: ○ **Y** ○ **N**				
Neck,Trunk and Pelvic Posture and Flexibility: ____ **Good** ____ **Limited** ____ **Serverly Limited**				

Mobility Assistive Equipment - Face to Face Examination Report

Functional Assessment			
	Question	**Your 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 Daily Living (MRADLs) in the home ?**	○ **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 ?**	○ **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 deflict be safety resolved by a cane or walker ?**	○ **YES** ○ **NO**	**STOP - ORDER CANE OR WALKER** **GO TO QUESTION 5**
5.	**Does 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 extremly function to safety propel a manual wheelchair to participate in MRADLs in the home ?**	○ **YES** ○ **NO**	**STOP - ORDER MANUAL WHEELCHAIR** **GO TO QUESTION 7**

7.	**Does your patient have sufficient and trunk stability to operate a POV in the home ?**	◯ **YES** ◯ **NO**	**GO TO QUESTION 8** **GO TO QUESTION 9**
8.	**Is your patient able to safely manueuver a POV in their home ?**	◯ **YES** ◯ **NO**	**GO TO QUESTION 8** **GO TO QUESTION 9**
9.	**Does your patient need the additional features (i.e. optimal maneuverability, ease of use, upgradable/adaptable seating etc.) of a power wheelchair to participate in MRADLs in the home.?**	◯ **YES** ◯ **NO**	**Go To Question 10** **STOP - NO MAE**
10.	**Is your patient safe and able to maneuver a power 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:-** _____

Need patients chart notes.

Basinger's Pharmacy

Basinger's Pharmacy Marycrest ,2130 W Jefferson St , Joliet, IL 60435 , Phone: (815)725-1102, Pharmacy Fax: (815)725-7500)

Medication Transfer Sheet/Release of Responsibility

Name of Facility: _____

Name of Resident: _____

_____

Date of Release: Expected Date of Return:

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

Transferring medications for home visits, outings, etc. Taken from Community Care Licensing technical support program medications.

- When a consumer/resident leaves a facility for a short period of time during which only one dose of medication(s) is/are needed, the facility may give consumer/resident medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, consumer/resident's name, name of medication(s), and instructions for administering the dose.
- If consumer/resident is to be gone for more than one dosage period, the facility may:

a. Give the full prescription contained to the consumer/resident, or responsible person/authorized representative.

OR

b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.

OR

c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: _____
Received by: _____ Date: _____ Time: _____
Signature of person returning unused medications: _____
Staff signature of count on return: _____ Date: _____ Time: _____