Seating/Mobility Evaluation

To be completed by Physiatrist or Physical/Occupational Therapist
In Association With Mobility Device Specialist

PATIENT INFORMATION:

Name:	**DOB:** **Sex:**	**Evalution Date:**
Address:	**Physician:**	**This form will serve as the LMN for the following Suppliers:** **Primary:** **Contact Name:** **Phone #:** **Rehabilitation Engineering Program or 2nd Supplier:** **Contact Name:** **Phone #:**
	Mobility Device Therapist: **License #:** **Phone #:**	
Phone #:	**Mobility Device Specialist:** **Title:** **Phone:**	
Spouse/Parent/Caregiver/Guardian Name: **Relationship:** **Phone #:**	**Primary Therapist:** **Phone #:** **Insurance/Payer:** **Patient Recipient #:**	
Reason for Raferral:		
Patient Goals:		
Caregiver Goals and Specific Limitations that May Effect Care:		

MEDICAL HISTORY:

Primary Diagnosis: **Secondary Diagnosis:**		**Onset:**	
☐ Progressive Disease	**Relevant Past and Future Surgeries:**		
Height:	**Weight:**	**Describe Changes Past 2-5 years-Include Seating Measurements If Relevant:**	
Cardio Status:	**Functional Limitations:**		
☐ Intact ☐ Impaired ☐ Severely Impaired ☐ NA			
Respiratory Status:	**Functional Limitations:**		
☐ Intact ☐ Impaired ☐ Severely Impaired ☐ NA			
Orthotics		**Amputee** ☐ Yes ☐ No	

HOME ENVIRONMENT

☐ Home ☐ Condo/Town Home ☐ Apartment ☐ Asst Living ☐ Own ☐ Rent

☐ Lives Alone ☐ Lives with Others (Who?) | **Hours with caregiver:**

☐ Home is Accessible to Equipment Storage of Wheelchair: ☐ In Home ☐ Other Stairs: ☐ Yes ☐ No

Comment:(Describe management of equipment if stairs present - Describe security of Storage if Other is Checked)

COMMUNITY ADL:

TRANSPORTATION:

☐ Car ☐ Van ☐ Public Transportation ☐ Adapted W/C Lift ☐ Ambulance ☐ Other

Where is W/C Stored During Transport ? | ☐ Tie Downs

☐ Self Driver | Drive While in Wheelchair ☐ Yes ☐ No

Employment:

Specific Requirements Pertaining to Mobility:

School:

Specific Requirements Pertaining to Mobility:

Other:

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: ☐ Right ☐ Left ☐ NA Comments:

Visual Acuity Is Adequate For Safe Wheelchair Operation: ◯ Yes ◯ No

Processing Skills are Adequate for Safe Wheelchair Operation ◯ Yes ◯ No

Comments - Describe Limitations:

COMMUNICATION:

Verbal Communication: ☐ WFL Receptive ☐ WFL Expressive ☐ Understandable ☐ Difficult to Understand

☐ Non-Communicative ☐ Uses An Augmetative Communication Device **Manufacturer/Model:**

AAC Mount Needed:

SENSATION and SKIN ISSUES

Sensation ☐ Intact ☐ Impaired ☐ Absent ☐ Hyposensate ☐ Hypersensate ☐ Defensiveness Level of sensation:	**Pressure Relief** **Able to perform Effective Pressure Relief:** ☐ Yes ☐ No **Method:** **If not, Why?**	
Skin Issues/Skin Integrity **Current Skin Issues** ☐ Yes ☐ No ☐ Intact ☐ Red Area ☐ Open Area ☐ Scar Tissue ☐ At Risk from Prolonged Sitting **Where**	**History of Skin Issues** ☐ Yes ☐ No **Where** **When**	**Hx of Skin Flap Surgeries** ☐ Yes ☐ No **Where** **When**
Complaint of Pain: (Describe Location, Severity (Scale 1-10), Acute or Chronic, And How it Interferes With Ability To Operate Equip.)		

ADL STATUS (In Reference to Wheelchair Use):

	Indep	Assist	Unable	Indep with Equip	Not Assessed	Comments
Dressing	☐	☐	☐	☐	☐	
Eating	☐	☐	☐	☐	☐	**Describe Oral Motor Skills**
Grooming/Hygiene **bipap_adl_status_grooming_hygiene**	☐	☐	☐	☐	☐	
Meal Prep	☐	☐	☐	☐	☐	
IADLS	☐	☐	☐	☐	☐	
Bowel Mngmnt: ☐ Continent ☐ Incontinent ☐ Accidents						**Comments:**
Bladder Mngmnt: ☐ Continent ☐ Incontinent ☐ Accidents						**Comments:**

CURRENT SEATING/MOBILITY

Current Mobility Base: ☐ None ☐ Dependent ☐ Dependent with Tilt ☐ Manual ☐ Scooter ☐ Power **Type of Control:**				
Manufacturer: Pediatric ☐ Adult ☐	**Size:** Color:	**Model:** Age:	**Serial #;**	
Current Condition of Mobility Base:				
Current Seating System:			**Age of Seating System:**	

COMPONENT	**MANUFACTURER/CONDITION**		
Seat Base			
Cushion			
Back			
Lateral Trunk Supports			
Thigh Support			
Knee Support			
Foot Support			
Foot Strap			
Head Support			
Pelvic Stabilization			
Anterior Chest/Shoulder Support			
UE Support			
Other (Tilt/Recline, etc)			
When Relevant:	**Overall Seat Height:**	**Overall W/C Length:**	**Overall W/C Width:**
Describe Posture in Present Seating System:			
Number of Hours/Day Spent in Wheelchair ?			

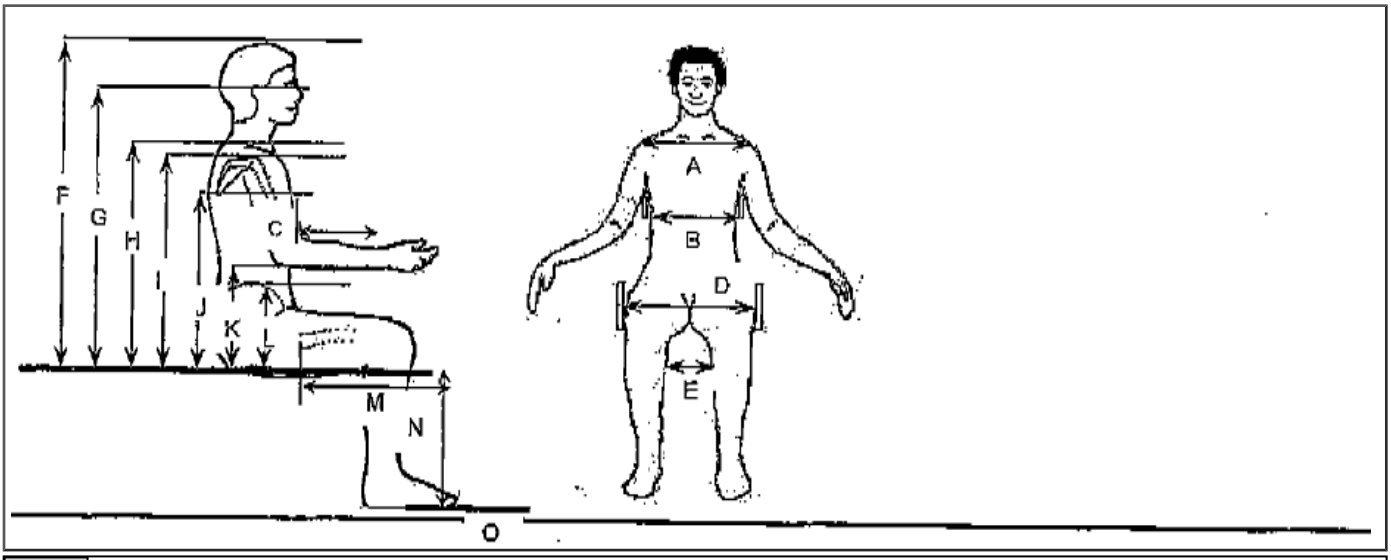
WHEELCHAIR SKILLS: (Shown by Trial) PT. IS TOTALLY DEPENDENT FOR MOBILITY YES ? NO ?

	Indep	**Assist**	**Dependent/ Unable**	**N/A**	**Comments**
Bed ? W/C Chair Transfers	☐	☐	☐	☐	
w/c ? Commodo Transfers	☐	☐	☐	☐	
Manual w/c Propulsion:	☐ **UE or LE Strength and Endurance Sufficient to Participate in ADLs Using Manual Wheelchair**				**Arm:** ☐ Left ☐ Right ☐ Both Foot: ☐ Left ☐ Right ☐ Both
Operate Scooter	☐ Strength, Hand Grip, Balance, Transfer Appropriate for Use. ☐ Living Environment Appropriate for Scooter Use.				
Operate Power W/C: Std. Joystick	☐	☐	☐	☐	☐ Safe ☐ Functional Distance
Operate Power W/C: W/ Alternative Controls	☐	☐	☐	☐	☐ Safe ☐ Functional Distance

MOBILITY/BALANCE:

Balance		Transfers	Ambulation
Sitting Balance	**Standing Balance**	☐ Independent	☐ Independent
☐ WFL	☐ WFL	☐ Min Assist	☐ Ambulates with Asst
☐ Uses UE for Balance in Sitting	☐ Min Assist	☐ Mod Asst	☐ Ambulates with Device
☐ Min Assist	☐ Mod Assist	☐ Max Assist	☐ Indep. Short Distance Only
☐ Mod Assist	☐ Max Assist	☐ Dependent	☐ Unable to Ambulate
☐ Max Assist	☐ Unable	☐ Sliding Board	
☐ Unable		☐ Lift/Sling Required	
Comments:			

MAT EVALUATION:



	Measurements in Sitting	Left	Right	
	A: Shoulder Width			**H: Seat to Top of Shoulder**
	B: Chest Width			**I: Acromium Process (Tip of Shoulder)**
	C: Chest Depth (Front - Back)			**J: Inferior Angle of Scapula**
	D: Hip Width			**K: Seat to Elbow**
	E: Between Knees			**L: Seat to Iliac Crest**
	F: Top of Head			**M: Upper leg length**
	G: Occiput			**N: Lower leg length**
	++: Overall width (asymmetrical width for windswept legs or scoliotic posture)			**O: Foot Length**

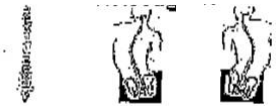
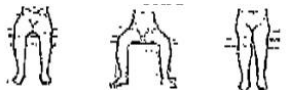
Additional Comments:

Hamstring flexibility:

Pelvis to Thigh angle ☐ accommodate greater than 90 **Thingh to calf angle** ☐ accommodate less than 90

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

EXPLAIN WHY PATIENT IS NON-AMBULATORY:

Posture				Comments
PELVIS	**Anterior / Posterior**  ☐ Neutral ☐ Posterior ☐ Anterior ☐ Fixed ☐ Partly Flexible ☐ Flexible ☐ Other	**Obliquity**  ☐ WFL ☐ R elev ☐ l elev ☐ Fixed ☐ Partly Flexible ☐ Flexible ☐ Other	**Rotation-Pelvis**  ☐ WFL ☐ Right Anterlor ☐ Left Anterlor ☐ Fixed ☐ Partly Flexible ☐ Flexible ☐ Other	
TRUNK	**Anterior / Posterior**  ☐ WFL ☐ Thoracic Kyphosls ☐ Lumbar Lordosis ☐ Fixed ☐ Partly Flexible ☐ Flexible ☐ Other	**Left Right**  ☐ WFL ☐ Convex Left ☐ Convex Right ☐ c-curve ☐ s-curve ☐ multiple ☐ Fixed ☐ Partly Flexible ☐ Flexible ☐ Other	**Rotation-Shoulders and upper trunk**  ☐ Neutral ☐ Left-anterior ☐ Right-anterior ☐ Fixed ☐ Partly Flexible ☐ Flexible ☐ Other	
	Describe LE Neurological Influence/Tone:			
HIPS	**Position**  ☐ Neutral ☐ Abduct ☐ Adduct ☐ Fixed ☐ Subluxed ☐ Partly Flexible ☐ Dislocated ☐ Flexible	**Windswept**  ☐ Neutral ☐ Right ☐ Left ☐ Fixed ☐ Partly Flexible ☐ Flexible ☐ Other	**Hip Flexion/Extension Limitations:** **Hip Internel/External Range of motion Limitation:**	
KNEES & FEET	**Knee R.O.M** Left ☐ WFL ☐ Limitations Right ☐ WFL ☐ Limitations		**Foot Positioning** ☐ WFL ☐ L ☐ R **ROM Concerns:** **Dorsi-Flexed** ☐ L ☐ R **Plantar Flexed** ☐ L ☐ R **Inversion** ☐ L ☐ R **Eversion** ☐ L ☐ R	
HEAD & NECK	☐ Functional ☐ Flexed ☐ Extended ☐ Lat Flexed L ☐ Rotated L ☐ Lat Flexed R ☐ Rotated R ☐ Cervical Hyperexlesion	☐ Good Head Control ☐ Adequate Head Control ☐ Limited Head Control ☐ Absent Head Control	**Describe Tone/Movement of head and Neck:**	

UPPER EXTREMITY	**SHOULDERS** Left Right ☐ Functional ☐ Functional ☐ elev / dep ☐ elev / dep ☐ pro-retract ☐ pro-retract ☐ subluxed ☐ subluxed	**R.O.M. for Upper Extremity** ☐ WNL ☐ WFL Limitations: **UE Strength (X/5)** ☐ N/A ☐ None ☐ Concerns	**Describe Tone/Movement of UE:**	
	ELBOWS Left Right	**R.O.M.** **Strength (X/5)** **Strength concerns:**		
WRIST & HAND	Left Right ☐ Fisting	**Strength / Dexterity: (X/5)**		

Goals for Wheelchair Mobility

- ☐ Independence with mobility in the home and mobility related ADLs (MRADLs) in the community.
- ☐ Independence with MRADLs in the community
- ☐ Provide dependent mobility
- ☐ Provide recline
- ☐ Provide tilt ☐

Goals for Seating System

- ☐ Optimize pressure distribution
- ☐ Provide support needed to facilitate function or safety
- ☐ Provide corrective forces to assist with maintaining or improving posture
- ☐ Accommodate client's posture: current seated postures and positions are not flexible or will not tolerate corrective forces
- ☐ Client to be independent with relieving pressure in the wheelchair
- ☐ Enhance physiological function such as breathing, swallowing, digestion

Equipment Trial: (Must be of adequate duration to demonstrate independence for patient with previous dependent mobility.)

Describe Duration and Location of Trial:

Patient Demonstrated Ability To Use Equipment Safely & Efficiently ☐ Yes ☐ No Comments:

State why other equipment was unsuccessful:

RECOMMENDATIONS & JUSTIFICATION (Lowest Appropriate Group Must Be Recommended)

MOBILITY BASE	JUSTIFICATION
Mfgr: _____ **Model:** _____ **Seat Width:** _____ **Seat Depth:** _____ **Can Be Grown To: (Must Complete)** **Seat Width:** _____ **Seat Depth:** _____	☐ Provide transport from point A to B ☐ Promote Indep mobility ☐ Is not a safe, functional ambulator ☐ walker or cane, inadequate ☐ Non-standard width/depth necessary to accommodate anatomical measurement ☐ Other
☐ Manual Mobility Base	☐ Non-functional ambulator
☐ Scooter/POV	☐ Can safely operate ☐ has adequate trunk stability ☐ Can safely transfer ☐ Can not functionally propel manual wheelchair
☐ Power Mobility Base	☐ Can not functionally propel manual wheelchair ☐ Non-ambulatory ☐ Can not functionally and safely operate scooter/POV
☐ Stroller Base	☐ infant/child ☐ Unable to propel manual wheelchair ☐ allows for growth ☐ non-functional ambulator ☐ non-functional UE ☐ Indep mobility is not a goal at this time
Reasons This Particular WC was chosen for Patient ?	
Why isn't a Lower Group Appropriate for Patient ?	
Tilt Base or added ? **Forward** ? **Backward** ? **Powered tilt on powered chair** ? **Powered tilt on manual chair** ? **Manual tilt on manual base**	☐ change position against gravitational force on head and shoulders ☐ change position for pressure relief/can not weight shift ☐ transfers ☐ management of tone ☐ rest periods ☐ control edema ☐ facilitate postural control ☐ Other
Recline ? **Power recline on power base** ? **Manual recline on manual base**	☐ accommodate femur to back angle ☐ bring to full recline for ADL care ☐ change position for pressure relief/can not weight shift ☐ rest periods ☐ respositioning for transfers or clothing / diaper / catheter changes ☐ head positioning
☐ Transportation tie-down option	☐ To provide crash tested tie down brackets
Elevator on Mobility Base ? **Wheelchair** ? **Scooter**	☐ increase indep in transfers ☐ increase indep in ADLs ☐ raise height for communication at standing level ☐ Other
Push handles ? **extended** ? **angle adjustable** ? **standard**	☐ caregiver access ☐ caregiver assist ☐ allows "hooking" to enable increased ability to perform ADLs or maintain balance
Lighter weight required	☐ Self propulsion ☐ lifting ☐ Other
Heavy Duty required	☐ user weight greater than 250 pounds ☐ extreme tone ☐ over active movement ☐ broken frame on previous chair ☐ multiple seat functions ☐ Other
Specific Seat height required **Floor to seat height**	☐ Foot Propulsion ☐ transfers ☐ accommodation of leg length ☐ access to table or desk top ☐

MOBILITY BASE	JUSTIFICATION	
Rear wheel placement/Axle adjustability ? None ? semi adjustable ? fully adjustable	☐ Improved UE access to wheels ☐ Improved stability ☐ changing angle in space for improvement of postural stability	☐ 1-arm drive access ☐ amputee placement ☐ Other
Angle Adjustable Back	☐ Postural Control ☐ Control of tone/spasticity ☐ accommodation of range of motion	☐ UE functional control ☐ accommodation for seating system ☐ Other
POWER WHEELCHAIR CONTROLS ☐ Proportional Type: Body Parts: ◯ Left ◯ Right ☐ Non-Proportional/switches Type: Body Parts: **Upgraded Electronics** ☐ Other ☐ Display box ☐ Digital interface electronics ☐ ASL Head Array ☐ Sip and puff tubing kit ☐ Upgraded tracking electronics ☐ Safety Reset Switches ☐ Single or Multiple Actuator Control Module	☐ Provides access for controlling wheelchair ☐ lacks motor control to operate proportional drive control ☐ Unable to understand proportional controls ☐ Programming for accurate control ☐ progressive Disease/changing condition ☐ Needed in order to operate power/tilt through joystick control ☐ Allows user to see in which mode and drive the wheelchair is set; necessary for alternative controls ☐ Allows w/c to operate when using alternative drive controls ☐ Allows client to operate wheelchair through switches placed in tri-panel headrest ☐ needed to operate sip and puff drive controls ☐ increase safety when driving ☐ correct tracking when on uneven surfaces ☐ Used to change modes and stop the wheelchair when driving in latch mode ☐ Allow the client to operate the power seat function(s) through the joystick control	**If Expandable Controller Recommended Provide Additional Narrative In space At End Of Form re Why Patient Requires Expandable Controller vs. Non-Expandable Controller** ☐ Non-proportional drive control needed (Explain)
☐ Mount for switches or joystick	☐ attaches switches to w/c ☐ swing away for access or transfers	☐ midline for optimal placement ☐ provides for consistent access
Attendant controlled joystick plus Mount	☐ safety ☐ long distance driving ☐ operation of seat functions	☐ compliance with transportation regulations ☐ Other
Battery	☐ power motor on wheelchair	
Charger	☐ charge battery for wheelchair	
Push rim active assist	☐ enable propulsion of manual wheelchair on sloped terrain	☐ enable propulsion of manual wheelchair for distance
Hangers/Leg rests ☐ 60 ☐ 70 ☐ 90 ☐ elevating ☐ heavy duty ☐ articulating ☐ fixed ☐ lift off ☐ swing away ☐ rotational hanger brackets ☐ adjustable knee angle ☐ adjustable calf panel ☐ Longer extension tube	☐ Provide LE Support ☐ accommodate to harmstring tightness ☐ elevate legs during recline ☐ provide change in position for les ☐ Provide LE Support ☐ maintain placement of feet on footplate	☐ durability ☐ enable transfers ☐ decrease edema ☐ Accommodate lower leg length ☐ Other

Foot support ☐ adjustable Footplate ☐ R ☐ L ☐ flip up ☐ depth/angle adjustable	☐ Provide foot Support ☐ accommodate to ankie ROM ☐ allow foot to go under wheelchair base	☐ transfers ☐ Other
Armrests ☐ fixed ☐ adjustable height ☐ removable ☐ swing away ☐ flip back ☐ reclining ☐ full length pads ☐ desk ☐ pads tubular	☐ Provide Support with elbow at 90 ☐ provide support for w/c tray ☐ changes of height/angles for variable activities	☐ remove for transfers ☐ allow to come closer to table top ☐ remove for access to tables ☐ Other
Side guards	☐ prevent clothing getting caught in wheel or becoming soiled	
Wheel size: **Wheel Style:** ☐ mag ☐ spokens ☐ Other	☐ increase access to wheel ☐ allow for seating system to fit on base	☐ increase propulsion ability ☐ maintenance ☐
Quick Release Wheels	☐ allows wheels to be removed to decrease width of w/c for storage	☐ decrease weight for lifting ☐ Other
Wheels rims/ hand rims ☐ metal ☐ plastic coated ☐ vertical projections ☐ oblique projections	☐ provide ability to propel manual wheelchair	☐ increase self-propulsion with hand weakness/decreased grasp
Tires ☐ pneumatic ☐ flat free inserts ☐ solid	☐ decrease maintenance ☐ prevent frequent flats ☐ increase shock absorbency	☐ decrease pain from road shock ☐ decrease spasms from road shock ☐ Other
Caster Housing: **Caster Size:** **Style:**	☐ maneuverability ☐ stability of wheelchair ☐ increase shock absorbency ☐ durability ☐ maintenance ☐ angle adjustment for posture	☐ decrease pain from road shock ☐ decrease spasms from road shock ☐ allows for feet to come under wheelchair base ☐ allows change in seat to floor height ☐
Shock absorbers	☐ decrease vibration	☐ provide smoother ride over rough terrain
Spoke Protector	☐ prevent hands from getting caught in spokes	☐ Other
One armed device ☐ Left ☐ Right	☐ enable propulsion of manual wheelchair with one arm	☐ Other
Anti-tippers	☐ prevent wheelchair from tipping backward	☐
Amputee adapter	☐ provide support for stump/residual extremity	
☐ Crutch/cane holder ☐ Oxygen Cylinder holder ☐ IV hanger	☐ stabilize accessory on wheelchair	
Brake/Wheel lock extension ☐ R ☐ L		☐ increase indep in applying wheel locks
Other:		
Other:		

SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manuf/mod/size	Justification	
Seat Cushion		☐ accommodate impaired sensation ☐ decubitus ulcers present ☐ prevent pelvic extension ☐ low maintenance	☐ stabilize pelvis ☐ accommodate obliquity ☐ accommodate multiple deformity ☐ neutralize LE ☐ increase pressure distribution ☐
Seat Wedge		☐ accommodate ROM	☐ Provide increased aggressiveness of seat shape to decrease sliding down in the seat
Cover Replacement		☐ protect back or seat cushion	☐ Other
Mounting hardware **lateral trunk supports** **headrest medial thigh support** **back seat**	**Fixed** **swing away for:**	☐ attach seat platform/cushion to w/c frame ☐ attach back cushion to w/c frame	☐ mount headrest ☐ swing medial thigh support away ☐ swing lateral supports away for transfers
Seat Board **Back Board**		☐ support cushion to prevent hammocking	☐ allows attachment of cushion to mobiliy base
Back		☐ provide lateral trunk support ☐ accommodate deformity ☐ accommodate or decrease tone ☐ facilitate tone	☐ provide posterior trunk support ☐ provide Lumbar/sacral support ☐ support trunk in midline ☐ Other
Lateral Pelvic/thigh support		☐ pelvis in neutral ☐ accommodate pelvis ☐ position upper legs	☐ accommodate tone ☐ removable for transfers ☐
Medial knee Support		☐ decrease adduction ☐ accommodate ROM	☐ remove for transfers ☐ alignment
Foot Support		☐ position foot ☐ accommodate deformity	☐ stability ☐ decrease tone ☐ control position
Ankle strap/heel loops		☐ support foot on foot support ☐ decrease extraneous	☐ provide input to heel ☐ protect foot
Lateral trunk Supports	☐ R ☐ L	☐ decrease lateral trunk leaning ☐ accom asymmetry ☐ contour for increased contact	☐ safety ☐ control of tone ☐ Other
Anterior chest strap, vest, or shoulder retractors		☐ decrease forward movement of shoulder ☐ accommodation of TLSO decrease forward movement of trunk	☐ added abdominal support ☐ alignment ☐ assistance with shoulder control ☐ decrease shoulder elevation ☐ Other
Headrest		☐ provide posterior head support ☐ provide posterior neck support ☐ provide lateral head support ☐ provide anterior head support ☐ support during tilt and recline ☐ improve feeding	☐ improve respiration ☐ placement of switches ☐ safety ☐ accommodate ROM ☐ accommodate tone ☐ improve visual orientation

Neck Support		☐ decrease neck rotation	☐ decrease forward neck flexion
Upper Extremity Support **Arm trough** **Posterior hand support** **1/2 tray** **full tray** **full tray**	☐ R ☐ L	☐ decrease edema ☐ decrease subluxation ☐ control tone ☐ provide work surface ☐ placement for AAC/Computer/EADL	☐ decrease gravitational pull on shoulders ☐ provide midline positioning ☐ provide support to incease UE functions ☐ provide hand support in natural position
Pelvic Positioner		☐ stabilize tone ☐ decrease falling out of chair/will not decrease potential for sliding due to pelvic titling ☐ Prevent excessive rotation	☐ pad for protection over boney prominence ☐ prominence comfort ☐ special pull angle to control rotation ☐ Other
Bag or pouch		**Holds:** ☐ medicines ☐ special food ☐ orthotics ☐ clothing changes	☐ diapers ☐ catheter/hygiene ☐ ostomy supplies ☐ Other
Other:			

ADDITIONAL NARRATIVE DOCUMENTATION (MUST BE LEGIBLE)

SIGNATURES SHOWN BELOW MUST BE COMPLETED!

Patient/Client/Caregiver/ Guardian Signature:		**Date:**
Therapist Name/Title Printed:		
Therapist's Signature		**Date:**
Supplier's Rep/Title Printed		
Supplier's Rep Signature:		**Date:**

This is to certify that I, the above signed therapist have the following affiliations:

- ☐ This DME Provider
- ☐ Manufacturer of Recommended Equipment
- ☐ Patient's Long Team Care Facility
- ☐ None of the above

My signature below certifies that I agree with the recommendations above and order the equipment shown on the provider's itemized price list.

Physician's Signature: **Date:**

Need patients chart notes.

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: _____

noridian
Healthcare Solutions

SIGNATURE ATTESTATION STATEMENT

Medicare requires that services be authenticated by the persons responsible for the care of the beneficiary. The treating physician's/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided. If the signature is illegible, MACs, UPICs, SMRC, and CERT shall consider evidence in a signature log, attestation statement, or other documentation submitted to determine the identity of the author of a medical record entry. If the signature is missing from any other medical documentation (other than an order), MACs, SMRC, and CERT shall accept a signature attestation from the author of the medical record entry. Providers should not add late signatures to the medical record, (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. Note: Contractors cannot request or accept an attestation for a late signature for an order that is not signed. For complete CMS requirements, see to CMS Internet Only Manual (IOM), Publication 100-08, Chapter 3, Section 3.3.2.4.

This attestation form is provided as a courtesy for providers to refer to and/or use. This is not a required form. Providers may develop their own attestation form, if desired.

Beneficiary Information	
Beneficiary Name	
Date of Birth	Medicare Beneficiary Identifier (MBI)

Attestation Statement

I, _____ (print full name of physician/practitioner), hereby attest that the medical record entry for _____ [date(s) of service/visit/progress note] accurately reflects signature/notations that I made in my capacity as a(n) _____ (the author's credentials, e.g. MD) when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission or concealment of material fact may subject me to administrative, civil or criminal liability.

Signature of Medical Record Author	Date of Signature

In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry. Reviewers will not consider attestation statements where there is no associated medical record entry or someone other than the author (even a partner in the same group practice) of the medical record entry in question signs this statement. Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements).