



Power Mobility Device Evaluation

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



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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"/> Non-Ambulatory	<input type="checkbox"/> Max. Assist	<input type="checkbox"/> Mod. Assist
	<input type="checkbox"/> Shuffling	<input type="checkbox"/> Normal	<input type="checkbox"/> Ataxic
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: _____



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Current Mobility Related Activities for Daily Living (MRADL) Status

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 so 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
- Patient has significant edema of lower extremities that requires having an elevated leg rest
- Patient meets criteria for and has reclining back on wheelchair

Patient requires 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
- Patient utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed

Patient requires adjustable height armrests

Examples of limitations/conditions include:

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

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

Patient requires joystick controller

Patient cannot operate handlebar controller

Other: _____

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 equipment 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: _____