Enexia Healthcare

718-981-9000 FAX 718 509-3578

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)

1. What medical conditions/diseases limit your patient's mobility in their home?

☐ CHF	☐ COPD	☐ CVA	☐ Degenerative Joint Disease	☐ Diabetes/ Neuropathy
☐ Hemiparesis	☐ Hemiplegia	☐ Multiple Sclerosis	☐ Muscular Dystrophy	☐ Osteoarthritis
☐ Paraparesis	☐ Paraplegia	☐ Parkinson's Disease	☐ Renal Failure	☐ Rheumatoid Arthritis

☐ Other, please describe: _____

2. Symptoms

☐ Abnormal Gait	☐ Amputation	☐ Cardiac Arrhythmias	☐ Chest Pain	☐ Fatigue
☐ Intermittent Claudication	☐ Muscular Dystrophy	☐ Orthostasis	☐ Paralysis	☐ Shortness of Breath
☐ Syncope	☐ Tremor	☐ Vertigo	☐ Walking Limitations	☐ Weakness

☐ Other, please describe: _____

3. Pain Location

☐ Head	☐ Face	☐ Neck	☐ Chest	☐ Abdomen
☐ Pelvis/Groin	☐ Upper Back	☐ Lower Back	☐ Sacrum	☐ R/L Shoulder
☐ R/L Arm	☐ R/L Elbow	☐ R/L Wrist/Hand	☐ R/L Hip/Thigh	☐ R/L Knee
☐ R/L Ankle/Foot	☐ Other, please describe: _____			

Physical Exam (Must be completed by physician or treating practitioner)

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

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

1. Functional Ambulatory Limitations (Complete all limitations that apply)

Gait/Walk Pattern	☐ Normal	☐ Ataxic	☐ Shuffling
	☐ Mod. Assist	☐ Max. Assist	☐ Non-Ambulatory

Limitation	Onset	Description	Diagnosis
Balance/History or Risk of Falls			
Fatigue/Weakness			
Inability to Ambulate			
Other: _____			

2. Physical Limitations (Check all limitations that apply and describe all non-normal findings)

Upper Body Weakness	☐	Mild	☐	Moderate (Describe) _____	☐	Severe (Describe) _____
Upper Body Pain	☐	Mild	☐	Moderate (Describe) _____	☐	Severe (Describe) _____
Upper Body Range of Motion	☐	Normal	☐	Partially Limited (Describe) _____	☐	Severely Limited (Describe) _____
Lower Body Weakness	☐	Mild	☐	Moderate (Describe) _____	☐	Severe (Describe) _____
Lower Body Pain	☐	Mild	☐	Moderate (Describe) _____	☐	Severe (Describe) _____
Lower Body Range of Motion	☐	Normal	☐	Partially Limited (Describe) _____	☐	Severely Limited (Describe) _____

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Ambulatory Status in Relation to Mobility Related Activities of Daily Living (MRADL) in Home

1. 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.)

2. Please select all MRADL that your patient is unable to accomplish in the home in a safe and timely fashion due to mobility limitations.

   ☐ Feeding ☐ Bathing ☐ Grooming ☐ Dressing ☐ Toileting ☐ Other: _____

3. 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: _____

   _____

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 MRADL inside the home?

   _____

   _____

   _____

Patient's Name: _____

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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 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 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'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: _____
   - ☐ None of the above limitations apply. Therefore the patient may not qualify for a power wheelchair, however the patient may qualify for a power operated vehicle/scooter.

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 **standard 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 **complex rehabilitation 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:** _____