

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 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 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 (severe weakness): Y N		Obesity: Y N		Significant Edema: Y N
Upper Extremity Weakness: Y N				
Upper Extremity ROM : ___ Good ___ Limited ___ Severely Limited				
Holds to furniture/walls for mobility: Y N				
Neck, Trunk and Pelvic Posture and Flexibility ___ Good ___ Limited ___ Severely Limited				
Describe patient's ability to walk in home:				

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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? If YES, why: _____ _____ _____	<input type="checkbox"/> YES	GO TO QUESTION 2 <input type="checkbox"/> NO
2. Can their limitations be compensated by the addition of Mobility Assistive Equipment (MAE) to improve the ability to participate in MRADLs in the home? If YES, why: _____ _____ _____	<input type="checkbox"/> YES	GO TO QUESTION 3 <input type="checkbox"/> NO
3. Is your patient or their caregiver capable and willing to operate the Mobility Assistive Equipment (MAE) safely in the home?	<input type="checkbox"/> YES <input type="checkbox"/> NO	GO TO QUESTION 4 STOP - NO MAE
4. Can their mobility deficit be safely resolved by a cane or walker? If NO, why: _____ _____ _____	<input type="checkbox"/> YES	STOP - ORDER CANE OR WALKER <input type="checkbox"/> NO
5. Does your patient's home environment support use of a wheelchair or Power Operated Vehicle (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	STOP - ORDER MANUAL WHEELCHAIR <input type="checkbox"/> NO
7. Does your patient have sufficient strength and trunk stability to operate a Scooter/Power Operated Vehicle (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 Scooter/Power Operated Vehicle (POV) in their 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, ease of use, upgradeable/adaptable seating, etc.) of a 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 a power 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:** _____