Functional Mobility Evaluation

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Section I PATIENT INFORMATION

Name: Birth Date: Medicare/Insurance#:

Address: City: State:

Phone: Sex: Height: Ft In Weight: lbs

NOTE: Supplier or practitioner must perform in-home assessment

In what type of environment does the patient reside?

(e.g., 1 story home, apartment complex - give full details including thresholds, floor coverings, door widths)

Home Environment Assessment:

- ☐ Living Room Wheelchair Accessible
- ☐ Kitchen Wheelchair Accessible
- ☐ Bedroom Wheelchair Accessible
- ☐ Bathroom Wheelchair Accessible
- ☐ Hallways Wheelchair Accessible
- ☐ Entrance Wheelchair Accessible

For any non-accessible area above, how will the patient accommodate this lack of access? For example, describe use of bedside commodes, home modification or ramps:

Section II MEDICAL EVALUATION

Instructions: This evaluation will take you through a step-wise process for prescribing mobility assistive equipment (MAE). Note that some patients may benefit from other modalities of treatment that do not involve mobility devices. Consider referral to a healthcare professional such as a physiatrist, physical or occupational therapist for a more detailed evaluation of the patient's mobility deficit and treatment options.

☐ **Check here if referral for further evaluation made**

Date of Eval: ICD-9 Diagnoses:

Subjective Complaint:

Describe any mobility assistive equipment the patient is currently using. Explain why this device is no longer medically appropriate. Document clinical progression, past interventions (if any) and the results of those interventions.

What is the patient's current mobility status to safely perform MRADL's such as toileting, feeding, dressing, grooming, bathing as well as other MRADL's such as meal preparation and home management? *(Document the distance the patient is able to move about in their home, both independently as well as with any currently used assistive device (including manual or power wheelchair), ability to transfer between bed, chair and PMD, physical assistance, and degree of assistance required):*

This Mobility Evaluation must be completed by the treating physician, Physical or Occupational Therapist, or a qualified healthcare practitioner. Completion of this Evaluation does not guarantee Coverage or Insurance Reimbursement Functional Mobility Evaluation - NCD/LCD Based (Version 5, 9-05)

Does the patient have limitations of mobility that impair his/her ability to participate in MRADLs either (Check One):

☐ 1. Entirely Limited ☐ 2. Can accomplish but with risk to safety ☐ 3. Can accomplish but not within reasonable time

Describe limiting symptoms such as dyspnea, weakness, fatigue, pain, imbalance, loss of range of motion, past falls:

Is the patient willing or does he/she have the cognition, judgment and/or vision to participate in MRADLs? ☐ Yes ☐ No

If No (cognition, judgment, visual impairment or other limitations exist), can MRADLs be accomplished with the assistance of a caregiver (e.g., caregiver pushing patient in wheelchair)? ☐ Yes ☐ No

Describe impairment requiring assistance of caregiver:

Will a cane or walker allow the patient to participate in MRADLs safely and in a timely manner?

☐ Yes ☐ No If yes, **STOP** - Order Cane, crutch or walker

If no, please describe symptoms preventing use of this type of equipment, including any safety-related issues such as history of, or potential for, falls or environmental barriers (e.g., thick carpet or rugs, high thresholds). Be specific.

Considering a manual wheelchair, does the patient have sufficient upper extremity and/or lower extremity strength or the endurance necessary to participate in MRADLs using an optimally configured manual wheelchair?

☐ Yes ☐ No If yes, **STOP** - Order manual wheelchair

(Optimally configured means lightest weight, proper wheelbase, appropriate axle position).
If no, please describe symptoms preventing use of a manual wheelchair. You do not need to describe symptoms that are the same as those precluding use of a cane, crutch or walker. Just state "see above."

POV/Scooter use requires a patient to have sufficient trunk strength, hand grip and upper extremity function, balance to sit upright, requires the ability to stand and pivot and typically more space in the home to maneuver. Given these requirements, in your assessment of this patient and their living environment, is a scooter appropriate?

☐ Yes ☐ No If yes, **STOP** - Order Scooter

If no, please describe the reason why a scooter is not an appropriate device. Be specific.

Considering a power wheelchair, does the patient have the functional ability to consistently access a drive control and the cognition, judgment, and visual ability to safely operate a power wheelchair to participate in MRADLs within the home environment?

☐ Yes ☐ No If yes, **STOP**... Order power wheelchair

If no, reconsider answer to caregiver assistance question and consider a device operated by a caregiver (e.g., manual wheelchair).

Other considerations or information relevant to evaluation including details such as presence of abnormal tone or deformity of arms, legs or trunk, absence or impairment of sensation, neck/trunk/pelvic posture and flexibility:

Physician Name (Print): UPIN:

Street Address: City: State: ZIP:

Telephone #:

Signature: Date: