FUNCTIONAL MOBILITY EVALUATION

THIS EVALUATION WILL GUIDE YOU THROUGH A STEP WISE PROCESS FOR PRESCRIBING MOBILITY PRODUCTS

PATIENT INFORMATION

Patient Name:		MBI:	
Address:		City:	Zip:
Phone:	DOB:	Height:	Weight:

MEDICAL EVALUATION

Date of Face-to-Face Evaluation: Length of Need:
ICD-10 Diagnoses:
Mobility devices currently used in the home: □Cane □Walker □Manual Wheelchair □Other:
Why are these no longer appropriate or safe?
1. Does the patient have mobility limitation(s) that significantly impairs his/her ability to perform one or more mobility related activity of daily living (MRADL)? □ Yes (Explain) □ No □ Safety □ Imbalance □ Weakness □ Dyspnea □ Pain □ Loss of ROM □ History of falls Other: _____
2. Are there other conditions that limit the patient's ability to participate in MRADL in the home? □ Yes □ No □ Vision □ Cognition □ Hearing If Yes, Please Explain: _____
3. Can the limitations be compensated sufficiently that the provision of mobility assistive equipment (MAE) will reasonably be expected to significantly improve the patient's ability to perform or obtain assistance to participate in MRADL in the home? □ Yes □ No If No, Please Explain _____
4. Does the patient or caregiver demonstrate the capability & willingness to operate the power mobility device in their home? □ Yes □ No
5. Can the functional mobility deficit be sufficiently resolved with the use of a cane or walker? □ Yes □ No
6. Does the patient's home support the use of wheelchairs including a power mobility device to be used in the home for completion of MRADL? □ Yes □ No
7. Does the patient have sufficient upper extremity function to self-propel a manual wheelchair in the home to complete MRADL? (Consider and document limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity) □ Yes □ No Explain: _____
8. Can the patient safely use a manual wheelchair? □ Yes □ No
9. Is there a caregiver who is available, willing and able to provide assistance? □ Yes □ No
10. Does the patient have sufficient trunk strength, postural stability, hand grip, motor coordination, balance to sit upright, ability to stand and pivot, transfer and space in the home to safely maneuver a power mobility device? □ Yes □ No
11. Does the patient need and have the judgment, mental and physical capabilities to safely use a power mobility device in the home in MRADL? □ Yes □ No
Physician's Name: _____ NPI#: _____ I certify that I am the treating physician identified in this form. I have received the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability. **Physician's Signature:** **Date:**