

Absolute Medical Equipment, Inc.

Patient Face to Face Evaluation

Patient Name: _____ DOB _____

Address: _____ Medicare# _____

What is the patient's mobility limitation and how does it interfere with the performance of activities of daily living? _____

Why can't a cane or walker meet this patient's needs in the home? _____

Why can't a manual wheelchair meet this patient's mobility needs in the home? _____

Why can't a scooter meet this patient's needs in the home? _____

Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home? _____

Please give as much information about the following as you can. You may attach office and progress notes relative to the following areas.

- Symptoms
- Related Diagnosis
- History
 - ▶ How long has the condition been present
 - ▶ Clinical progression
 - ▶ Interventions that have been tried and the results
 - ▶ Past use of walker, manual wheelchair scooter or power wheelchair and their results
- Physical exam
 - ▶ Weight
 - ▶ Impairment of strength, range of motion, sensation or coordination of arms and

- ▶ legs
- ▶ Presence of abnormal tone or deformity of arms, legs or trunk
- ▶ Neck, trunk and pelvic posture and flexibility
- ▶ Sitting and standing balance
- Functional assessment - any problems with performing the following activities including the need to use a cane, walker or assistance of another person
 - ▶ Transferring between a bed or chair
 - ▶ Walking around their home - please provide information on distance walked, speed and balance

Physical Therapist Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Physician Name: _____

Address: _____

Phone: _____

Please retain a copy of this evaluation for your files.

Algorithmic Approach to Coverage

Patient Name: _____ DOB _____

Address: _____ Phone: _____

Please answer the following line of questions to determine the appropriate Mobility Assistance Device. A copy of Medicare's Algorithmic Approach to Coverage is attached for your review.

- | | | |
|--|-----|---------------------------------|
| 1. Does patient have mobility limitation? | YES | NO |
| 2. Does patient have other limitations? | YES | NO |
| 3. Are other limitations compensated? | YES | NO |
| 4. Is patient capable of safe use of equipment? | YES | NO |
| 5. Can patient ambulate with a cane or walker? | YES | NO |
| 6. If "yes", is this mode of ambulation safe for patient? | YES | NO |
| 7. Is manual wheelchair appropriate for patient? | YES | NO |
| 8. If "yes", is manual wheelchair safe for patient? | YES | NO |
| 9. Which is most appropriate for patient?
<i>(please mark only one selection)</i> | | Motorized Wheelchair or Scooter |
| 10. If " scooter ", is scooter safe for patient? | YES | NO N/A |
| 11. If " power wheelchair ", is power wheelchair safe for patient? | YES | NO N/A |

Physician Signature

Date