|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** Click here to enter text. | **Date of Birth:** Click to enter | **Height:** Ft  | **Weight:** Pounds |

**Chief Diagnosis:** Click here to enter text.

|  |  |
| --- | --- |
| **Onset:** Click here to enter text. |  |

**Medical Diagnosis:**

Click here to enter text. Include clinical progress and how long condition has been present/change in condition, symptoms, diagnosis, progression, ambulation.

Past Medical History: Click here to explain relevant past medical history and history of present condition.

History of Falls: Click here to enter text. If no history of falls – delete.

**SUBJECTIVE REPORT:**

Click here to enter text. Please include pertinent information on why patient needs equipment, how their condition has changed, limitations, ect.

Mobility Goals: Please explain how patient’s limitation interferes with performance of ADLs and explain why participation in MRADL’s such as toileting, feeding, dressing, grooming, bathing, etc in their home **and how equipment will significantly improve the patient’s ability to participate in MRADLs**.

Patient is Coherent and cognitively intact: Click here to enter text. Please explain the patient has the mental capability to safely operate the equipment that is provided and that patient is willing and able to use the equipment in their home and have not expressed an unwillingness to use. (or that a caregiver is available to do so for them)

Social History/Home Environment: Please explain that the patient’s home provides adequate access between rooms, maneuvering space and surfaces for the operation of the equipment being provided.

Community Transportation: Please describe what transportation patient uses and how equipment is transported.

**OBJECTIVE FINDINGS**:

Current Medical Equipment and Condition of Medical Equipment and Seating: Describe what patient currently has and why it is no longer meeting their needs. (For replacement wheelchairs please include Make, Model, SN# and Date of purchase and why current equipment cannot be repaired or modified to meet their needs.)

Posture (seated):

* C-Spine: Click here to enter text.
* Shoulders: Click here to enter text.
* Upper Trunk: Click here to enter text.
* Lumbar: Click here to enter text.
* Pelvis: Click here to enter text.
* Hips: Click here to enter text.

Current Mobility Related Activities of Daily Living (MRADL’s): Please describe patient’s routine activities and what patient frequently encounters. Please address why patient’s ADL’s cannot be completed or why they cannot be completed in a timely manner. Please list level of independence that can be achieved. (If this is for an Ultralightweight wheelchair must include detailed description of patient’s routine activities inside and outside of home in detail and must be a highly active user.)

* Meal Preparation: Click here to enter text.
* Toileting: Click here to enter text.
* Bathing: Click here to enter text.
* Grooming: Click here to enter text.
* Upper and Lower Body Dressing: Click here to enter text.
* Home Management: Click here to enter text. Please address caregiver status and what they assist with.

Bed Mobility: Click here to enter text.

Transfer Skills: Choose Type of Transfer with Choose Level of Assistance Click here to elaborate or delete.

Toilet Transfer: Choose Type of Transfer with Choose Level of Assistance Click here to elaborate or delete.

Shower Transfers: Choose Type of Transfer with Choose Level of Assistance Click here to elaborate or delete.

Sitting Balance: Click here to enter text.

Standing Balance: Click here to enter text.

Gait: Click here to enter text.

Timed Up and Go (TUG) Test and results: Click here to enter text. Be sure to note if any MAE was used.

Joint Condition: Click here to enter text.

Palpation/Muscle: Click here to enter text.

Tone and Reflexes: Click here to enter text.

Ability to Weight Shift: Click here to enter text. Is patient able to independently and effectively perform an effective weight shift via lateral lean, wheelchair pushup, etc. Please list method tolerated. If not please list what methods were tried and failed and what limits patient’s ability to perform

Skin Condition: Please include level of risk, past or present history of skin breakdown.

Sensation: Click here to enter text.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Muscle Strength**: |  |  |  |  |
|  | Shoulders  | Left: | Select/5 | Right:  | Select/5 |
|  | Elbow  | Left: |  Select/5 | Right: | Select /5 |
|  | Wrist  | Left: | Select /5 | Right: | Select /5 |
|  | Grip Strength  | Left: |  Select/5 | Right: | Select /5 |
|  | Hips  | Left: |  Select/5 | Right: |  Select/5 |
|  | Knees  | Left: |  Select/5 | Right: |  Select/5 |
|  | Ankles  | Left: | Select /5 | Right: |  Select/5 |
| **Range of Motion:** |  |  |  |  |
|  | Shoulders Flexion  |  Left: | Enter Text  | Right: Enter Text  |
|  | Shoulders Abduction Left: | Enter Text  | Right: Enter Text  |
|  | Elbow  |  | Left: | Enter Text  | Right: Enter Text  |
|  | Wrist  |  | Left: | Enter Text  | Right: Enter Text  |
|  | Hip  |  | Left: | Enter Text  | Right: Enter Text  |
|  | Knee |  | Left: | Enter Text  | Right: Enter Text  |

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| --- |
| **Pain:** Click here to enter text. If pain restricts patient from using equipment/completing MRADLs, please describe.**Endurance:** Click here to enter text. Please list if patient was fully rested at time of evaluation. If endurance restricts patient from using equipment/completing MRADLs, please describe in detail their endurance level within their home environment and include levels of fatigue on a detailed timeline.**Cane / Rolling Walker:** Please address how far client can ambulate with assistive device or if client cannot ambulate with device why patient is unable to do so.**Optimally Configured Manual Wheelchair:** Please address how far client can propel while in wheelchair or if client cannot propel why patient is unable to do so to complete MRADLs.**Power Operated Vehicle:** Please address why or why not this device will meet patient’s needs**Power Wheelchair:** Please address why patient needs this device to complete ADLs and that patient is able and willing to use. Please also explain equipment selected will meet weight and measurement requirements of patient. |

**ASSESSMENT / RECOMMENDATIONS / PLAN:**

Click here to enter plan of care and recommended equipment for patient.

**JUSTIFICATION FOR ACCESSORIES:** *EXAMPLES OF JUSTIFICATION ARE LISTED BELOW PLEASE EDIT TO REFLECT INDIVIDIUAL NEEDS OF PATIENT*

Recommendations were discussed with patient and s/he is in agreement: [ ] Yes  [ ] No

This is to certify that the undersigned below does not have any financial affiliations with the DME Supplier/Provider providing this equipment.

Therapist Signature/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date.

Therapist Printed: Click here to enter text.

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Printed: Click here to enter text.

Physician’s Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_ By signing above and initialing here I have read and am in concurrence with the above recommendations and findings and agree for these items to be medically necessary.

\_\_\_\_\_\_\_\_ By signing above and initialing here I have read and am **not** in concurrence with the above recommendations and findings.