

## Patient Evaluation for Power Wheelchair (PMD)

| Section A  |                  | Patient Information           |                                    |  |  |
|--|------------------|-------------------------------|------------------------------------|--|--|
| Prescription Date:   | Patient Name:    | Date of Birth:                | Medicare HICN:                     |  |  |
|  | Address:         |                               |                                    |  |  |
| Face to Face Date:   | OT/PT Eval Date: | Diagnosis Code / Description: |                                    |  |  |
|  |                  |                               |                                    |  |  |
| Section B  |                  | Examination and Evaluation    |                                    |  |  |
| Please describe reason for this mobility evaluation: _____   |                  |                               |                                    |  |  |
| _____  |                  |                               |                                    |  |  |
| Height   | Weight           | B/P                           | Pulse                              | Respiratory  | Oxygen Used?   |
|  |                  |                               |                                    | <input type="checkbox"/> WNL <input type="checkbox"/> Labored at Times | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Current Pressure Sores? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                  |                               | Poor Balance?                      |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Location:  |                  |                               | History / Risk of Falls?           |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Trunk, Neck, and Pelvic Posture / Flexibility?   |                  |                               | Poor Endurance?                    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| <input type="checkbox"/> Good <input type="checkbox"/> Limited <input type="checkbox"/> Severely Limited   |                  |                               | Cachexia?                          |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Other Information  |                  |                               | Obesity?                           |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
|  |                  |                               | Significant Edema?                 |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
|  |                  |                               | Holds Walls/Furniture for Mobility |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| Section C  |                  | Functional Assessment         |                                    |  |  |
| 1. Does your patient have a mobility limitation that impairs participation in Mobility Required Activities of Daily Living (MRADLs) in the home? |                  |                               |                                    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| If Yes, Describe:  |                  |                               |                                    |  | Yes – Continue<br><b>STOP</b><br>No – No MAE                                   |
| 2. Can their limitations be compensated by the addition of MAE to improve the ability to participate in MRADLs in the home?                      |                  |                               |                                    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| If Yes, Why?:  |                  |                               |                                    |  | <b>STOP</b><br>No – No MAE<br>Yes – Continue                                   |
| 3. Is your patient or their caregiver capable and willing to operate the MAE safely in the home?   |                  |                               |                                    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
|  |                  |                               |                                    |  | <b>STOP</b><br>No – No MAE<br>Yes – Continue                                   |
| 4. Can the patient's mobility deficit be safely resolved by a cane or walker?  |                  |                               |                                    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| If No, Why?:   |                  |                               |                                    |  | <b>STOP</b><br>Yes – No MAE<br>No – Continue                                   |
| 5. Does your patient's home environment support use of a wheelchair or Power Mobility Device?  |                  |                               |                                    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
|  |                  |                               |                                    |  | <b>STOP</b><br>No – No MAE<br>Yes – Continue                                   |
| 6. Does your patient have the upper extremity function to safely propel a manual wheelchair to participate in MRADLs in the home?                |                  |                               |                                    |  | <input type="checkbox"/> Yes <input type="checkbox"/> No                       |
| If No, Why?:   |                  |                               |                                    |  | Yes - <input type="checkbox"/> Order Manual Wheelchair<br>No – Continue to PMD |



