



FUNCTIONAL MOBILITY EVALUATION

This Mobility Evaluation must be completed by a physical or occupational therapist, physiatrist the prescribing physician, or a qualified healthcare practitioner Completion of this evaluation does not guarantee coverage or insurance reimbursement, Functional Mobility Evaluation - NCO Based (Version 1. 7-05)

CHECK HERE IF SECTION V - REHAB SEATING, OPTIONS & ACCESSORIES HAS BEEN COMPLETED

Date of Evaluation: _____

Referred By: _____

SECTION I PATIENT INFORMATION

Name: _____ Birth Date: _____ Medicare/Insurance #: _____

Address: _____ City: _____ State: _____

Phone Number: _____ DOB: _____ Sex: _____ Height: _____ Weight: _____

In what type of environment does the patient reside? (Example 1 story home, apartment complex – give full detail) _____

SECTION II MEDICAL HISTORY

Date of onset of condition/injury: _____

Diagnosis(es) (include writtendescription and ICD - 9 code(s) _____

SECTION III ASSESSMENT

Assess the following in detail

1 - Does the patient have mobility limitation(s) that significantly impairs his/her ability to perform one or more MRADLs within the home? If so, please explain in detail what prevents the accomplishment or the MRADLs entirely, or; why it places the patient at heightened risk of morbidity or mortality when attempting MRADLs, or; prevents the completion of MRADLs in a reasonable time frame:

Yes No

Explain: _____

2 - Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?

Assess the patient's general systems (i.e. cognition. Judgment, vision), and list any other condition that limits the patient's ability to participate in MRADLs in the home.

Yes No

Explain: _____

Vision Hearing Communication Cognition Respiratory Eating

3 - If limitations exist, can they be compensated sufficiently such that the provision of MAE (Mobility



Assistive Equipment) will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home? A caregiver may be compensatory, if consistently available in the beneficiary's home and willing and able to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.

Yes No

Explain: _____

4 - Does the patient have a caregiver that is capable and willing to consistently operate the MAE safely?

Yes No

Explain: _____

Explain in detail whether or not the patient is able to safely use any of the following MAE (Mobility Assistive Equipment) when attempting to complete MRADL's within the home:

5 - Assess the patient's ability to use a cane/walker: Explain _____

6 - Does the patient's typical environment support the use of wheelchairs including scooter/poweroperated vehicles (POVs)? Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.

Yes No

Explain: _____

Has the patient's home been assessed for the placement of the proper MAE for the completion of the MRADLs?

Yes No

Explain: _____

- | | | | | | |
|------------------------------|-----------------------------|------------------------------------|------------------------------|-----------------------------|---------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Living Room Wheelchair Accessible? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kitchen Wheelchair Accessible? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bedroom Wheelchair Accessible? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bathroom Wheelchair Accessible? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hallways Wheelchair Accessible? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Entrance Wheelchair Accessible? |

7 - Assess the patient's ability to use a manual wheelchair (the wheelchair should be optimally configured). Does the patient have sufficient upper extremity function to propel a manual wheelchair in the home environment to participate in MRADLs during a typical day?

Yes No

Explain: _____

What are the patient's extremity strengths:

Upper: _____

Lower: _____

What (if any) ROM limitations are listed for this patient? _____

What is the patient's endurance level? _____

Describe the patient's gross/fine motor coordination: _____

Can the patient safely use a manual wheelchair?



Yes No

Explain: _____

Is there is a caregiver who is available, willing and able to provide assistance?

Yes No

Explain: _____

8 - Assess the patient's ability to use a POV/Scooter:

Does the patient have sufficient trunk strength and postural stability to operate a POV/scooter?

Yes No

Explain: _____

What is the patient's ability to transfer? _____

9 - Assess the patient's ability to use a power wheelchair:

Are there additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more Mobility Related Activities of Daily Living?

Yes No

Explain: _____

SECTION IV

EQUIPMENT RECOMMENDATIONS

Mobility Base - Specify make/model: _____

Options/Accessories/Wheelchair Seating:

Are any additional options, accessories and wheelchair seating being ordered for this patient?

Yes No

If so, please list the options, accessories and wheelchair seating being ordered/recommended as well as the medical necessity of the options, accessories and wheelchair seating for this specific patient.

OPTION/ACCESSORY

JUSTIFICATION

Evaluator Name/Title _____
License # _____
Street Address _____

Physician Name _____
UPIN _____
Street Address _____

City _____ State _____ ZIP _____
Telephone # _____
Signature _____
Date _____

City _____ State _____ ZIP _____
Telephone # _____
Signature _____
Date _____

SECTION V

REHAB SEATING, OPTIONS AND ACCESSORIES

MARK CHECK BOX ON PAGE 1 IF SECTION V HAS BEEN COMPLETED



SPECIAL SEATING REQUIREMENTS - (Please explain current limitations and any specialty seating required due to these limitations)

Sitting Posture/Balance: _____
Pelvic Tilt/ Obliquity/Rotation: _____
Leg Position: _____
Scoliosis: _____
Lordosis/Kyphosis: _____
Head Position: _____
Shoulder/Scapula Position: _____
Movement/Strength: _____
Tone/Spasms: _____
Skeletal/Physical Limitations/Deformities/Abnormalities: _____

SKIN CONDITION/INTEGRITY

Susceptible to decubitus ulcers: Yes No

If yes, explain: _____

Sensation: _____

Present/History of ulcers: _____

Location(s): _____

Ability to independently perform pressure relief: _____

Bowel/bladder status (toileting): _____

List rehab options, accessories and/or wheelchair seating being ordered/recommended as well as the medical necessity of the options, accessories and wheelchair seating for this specific patient.

OPTION/ACCESSORY

JUSTIFICATION

Evaluator Name/Title _____
License # _____
Street Address _____

Physician Name _____
UPIN _____
Street Address _____

City _____ **State** _____ **ZIP** _____
Telephone # _____
Signature _____
Date _____

City _____ **State** _____ **ZIP** _____
Telephone # _____
Signature _____
Date _____