Physical or Occupational Therapy Evaluation for a Power Mobility Device

Patient Name: _____ HICN: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ Male____ Female____ Height:_____ Wt:_____

Therapist Information:

Name: _____ Company: _____
Contact information: _____ Date of Evaluation: _____

1. Please describe this patients medical history and conditions that relate to limited mobility:
   _____
   _____
   _____
   _____
2. What mobility related activities of daily living are not possible for this patient inside of their home environment:
   _____
   _____
   _____
3. Does a current mobility device meet the needs of this patient inside of the home and if not, why is no longer safe or effective for this patient:
   _____
   _____
   _____
4. Describe the patients ambulation, risk or history of falls, transfers, etc:
   _____
   _____
   _____
5. Why can't this patient complete all of their ADL's within their home setting with a cane or a walker:
   _____
   _____
   _____
6. Describe any lower extremity weakness, pain, or conditions that limit the mobility of this patient (be quantitative and descriptive):
   _____
   _____
   _____
   _____
7. Why can't this patient use a manual wheelchair to complete all activities of daily living within their home setting:
   _____
   _____
   _____

8. Describe any limitations with the upper extremities along with any limits in range of motion, pain, strength and endurance levels with this patient (be quantitative and descriptive):

_____
_____
_____

9. Does this patient have any musculoskeletal, neurological, or respiratory conditions that effect their mobility and if so how:

_____
_____
_____

10. Is a Scooter with a larger turning radius, a good option for this patient to complete their ADL's within their home? Please explain:

_____
_____
_____

11. What are other developments that are probable if this patient does not obtain a power mobility device?

_____
_____
_____

12. Is this patient willing to use the PMD and physically and mentally capable of operating a power wheelchair:

_____
_____
_____

13. What are your recommendations or instructions for this patient along with any special seating or positioning needs and why:

_____
_____
_____

14. Check off any accessories needed on power w/c and explain need:
Elevating Leg Rests___ Adjustable Height Armrests___
Swing-Away-Joystick___ Oxygen Carrier___

Need: _____

I certify that I have completed this evaluation to the best of my medical training and that I do not have a financial relationship with the supplier for this recommended equipment.

Printed Name: _____ Signature: _____

As the treating practitioner, I concur with this evaluation and sign it into the medical progress notes for this patient.

Printed Name of Ordering Physician: _____

Signature: _____ Date: _____