

Power Mobility Device (PMD) Face-To-Face Evaluation

Patient: _____
 SS#: _____
 Insurance: _____
 Referring Doctor: _____

Date of Birth: _____
 MR#: _____
 Policy #: _____
 Date of Examination: _____

FACE-TO-FACE EVALUATION FOLLOW-UP – POST SPECIALTY EVALUATION

CHIEF COMPLAINTS & HISTORY OF PRESENT PROBLEM:

Patient is a ____ year old ____ left-handed / right-handed male / female who presents for a Face-to-Face evaluation complaining of _____

Functional Complaints

Functional Complaint	Onset	Description	Precipitating Activity	Relieving Action	Associated Diagnosis
Abnormal Gait					
Walking Limitations					
Intermittent Claudication					
Fatigue					
Shortness of Breath					
Chest Pain					

Current MRADL Status

MRADL	Independ	Needs Some Assist	Needs Total Assist	Independ with Equip	Not Assessed	Comments / Equipment Needed
Dressing						
Eating						
Grooming / Hygiene						
Toileting						
Bathing						

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Related Past Medical History:

Related Prior Hospitalization - Yes/ No; Date: _____ Reason: _____

Related Prior Medical / Surgical Management: MD/ orthopedic surgeon/ physiatrist/ chiropractor/ acupuncturist/neurologist/neurosurgeon: _____

Diagnostic and Functional Test Results:

Cardiac Stress Test –	
PFTs – (+) O2 Sat	
CT Scan &/or MRI	
6 Min. Walk Test	
Falls Risk Assessment	
(+)VO2-Max	

Related Diagnosis:

<input type="checkbox"/> CVA	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Hemi- plegia / paresis	<input type="checkbox"/> Coronary Heart Disease / Angina	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Paraplegia / paresis	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Diabetes with Sequelea	<input type="checkbox"/> Amputation
<input type="checkbox"/> COPD	<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Other Neuromuscular Condition
<input type="checkbox"/> Cancer	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other _____

Table 12 - Review of System: Significant as per history of present problem

General:	weight gain, weight loss, sleeping problems, fatigue, fever, chills, night sweats/ diaphoresis
Skin:	Pressure ulcer, rashes, changes in nails/ hairs, eczema, pruritus
Lymphatic:	swollen glands/ masses in the neck, axilla, groin
Head:	Fainting, dizziness, headache
Eyes:	Diplopia, glasses/ contact lenses, redness/ discharge, blurred vision, glaucoma, cataracts
Ears:	Tinnitus, discharge, hearing loss
Nose:	Epistaxis, sinus infections, discharge, polyps
Oral:	Dysphagia, hoarseness, teeth/ dentures
Neck:	Lumps, pain on movement
Breast:	Mass/ tumor, tenderness, discharge, gynecomastia
Pulmonary:	Cough, shortness of breath, pain, wheezing, hemoptysis, sputum production
Cardiac:	Chest pain, palpitations, orthopnea, murmur, syncope
Vascular:	Edema, claudications, varicose veins, thrombophlebitis, ulcers
Gastrointestinal:	Swallowing problems, abdominal pain, constipation, diarrhea, incontinence, nausea, vomiting, ulcers, melena, rectal bleeding, jaundice, heartburn, hematemesis
Renal:	Dysuria, frequency, urgency, hesitation, flank pain, hematuria, incontinence, nocturia, polyuria
Musculoskeletal:	Pain, swelling, stiffness, limitation of range of motion, arthritis, gout, cramps, myalgia, fasciculation, atrophy, fracture, deformity, weakness
Neurologic:	seizures, poor memory, poor concentration, numbness/ tingling, pins and needles sensation, hyperpathia, dysesthesia, weakness, paralysis, tremors, involuntary movements, unstable gait, fall, vertigo, headache, stroke, speech disorders
Psychiatric:	Hallucinations, delusions, anxiety, nervous breakdown, mood changes
Hematology:	Anemia, bruising, bleeding disorders
Endocrine:	Heat or cold intolerance, diabetes, lipid disorders, goiter

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PHYSICAL EXAMINATION:

A. General Medical Examination: Obese, overweight, normal weight, underweight _____ lbs

Vital Signs: BP- ____/____ PR- ____/min RR- ____/min

Pain Status (On a scale of 1 – 10) _____

HEENT: _____

Neck _____ Chest/Lungs _____

Heart _____

Abdomen _____ CVA Tenderness _____

B. Neurological Examination:

Cerebrum _____

Cranial Nerves _____

Cerebellum _____

Sensory intact decreased pinprick light touch _____

Gait- Limping/ antalgic ataxic hemiplegic waddling/ clumsy steppage

drunken/ staggering other _____ Assistive device _____

Motor Testing:

Pain with Movement- Yes/ No

Strength	Shoulder		Elbow		Wrist		Grip		Hip		Knee		Ankle	
	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Normal	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5
Flexion														
Extension														

C. Musculoskeletal Examination: (grimacing, groaning, limping, screaming, sweating, apprehension)

Spine: _____ scoliosis _____ lordosis- cervical/ lumbar _____ kyphosis,

Cervical Spine: _____

Lumbar Spine: _____

Upper Extremities: a. Shoulder _____ **b. Elbow** _____

c. Wrists- _____ **d. Hands- Thumb and Fingers-** _____

Lower Extremities: a. Hips _____ **b. Thighs** _____

c. Knees _____

d. Feet- Heels and Toes _____

Range of Motion: (See Range of Motion Chart)

Review of Records: (Specialty Evaluation)

Assessment Regarding Use of Medical Assist Equipment:

1. Use of a cane or walker:
 - a. Can the patient use a cane or walker: Yes; No
 - b. If the patient can not use a cane or walker what limitations support MRADLs will not be met in home? _____
2. Use of a manual wheelchair:
 - a. Can the patient use a manual wheelchair: Yes; No
 - b. If the patient can not use a manual wheelchair what limitations support MRADLs will not be met in home? _____
3. What are the patient's functional limitations that indicate and support the need for a Power Mobility Device (PMD)?

4. Physical and mental abilities:
 - a. Can the patient is physically and mentally able to operate a PMD: Yes; No
 - b. If the patient can not physically and mentally able to operate a PMD, what limitations support the patient is unable to operate a PMD in the home?

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5. Patient motivation:
- a. Is the patient motivated to operate a PMD: Yes; No
 - b. If the patient is not motivated to operate a PMD, what evaluation findings support he / she is not motivated to operate a PMD in the home?

6. Trained Caring Giver:
- a. Does the patient need a “Trained Caring Giver” to assist with MRADLs and to operate a PMD:
 Yes; No
 - b. If the patient needs a “Trained Caring Giver” to assist with MRADLs and to operate a PMD, what history and evaluation findings support he / she requires a “Trained Caring Giver” to assist with MRADLs and to operate a PMD in the home?

7. POV Does Not Meet the Needs of the Patient:
- a. Is the patient’s needs are not met with the use of a POV: Yes; No
 - b. What needs does the patient have that a POV would not provide to meet such needs:
 Requires use of a Joy Stick Controller Poor Trunk Stability Requires Adjustable Height Armrests Unable to Safely Operate a POV Requires Elevating Leg Rests Requires Fully Reclining Back Home Environment Space is Insufficient for Maneuverability
 - c. If the patient needs are not met with the use of a POV, what evaluation findings support he / she is unable to use a POV to meet MRADLs in the home?

Impression:

Recommended Treatment:

Discussion:

The patient underwent a Face-To-Face evaluation for a PMD on (Date) _____. The symptoms and clinical findings are consistent with the above diagnoses and functional limitations stated.

Based on this Face-To-Face evaluation the patient has functional limitations that support the need for a PMD and does not require further evaluation. (See the completed Seating/Mobility Evaluation form attached.)

Based on this Face-To-Face evaluation the patient has functional limitations that support the need for a PMD but a specialty evaluation is required. (A specialty Seating/Mobility Evaluation will be scheduled and a follow up assessment completed within the next 45 days.)

Based on this Face-To-Face evaluation the patient does not have functional limitations that support the need for a PMD and does not require further evaluation.

Prognosis: The prognosis is guarded/ fair/ poor at this time

Disability status: _____ Total _____ Partial

Affidavit:

I, Dr. _____, MD being a physician duly licensed and practicing in the State of _____ pursuant to _____ hereby affirm under the penalties of perjury that the statements contained herein are true and accurate.