



For patient needing power mobility device (PMD), information shown in step 1 and step 2 needs to be completed and provided to the DME supplier.

- Step 1: Complete the following items during your patient's mobility evaluation;
- A) *Face to Face Mobility Examination report*
 - B) *Prescription for power mobility device*
 - C) *Chart notes from the appointment indicating a mobility evaluation occurred*

Please fax items A, B, and C to Hometown Medical Supplies at (408) 493 - 4425.

- Step 2: After receiving all required paperwork, we will provide you with a detailed product description (DPD) finalizing the physician's order.

Thank you for cooperation and we look forward to meet the patient's need as quickly as possible. If there are any questions please contact us at your convenience.



Patient:

- ☞ Can patient self-propel a standard manual wheelchair? Yes No
- ☞ If Not, will power assisted device help Yes No
- Reason(s) of necessity? _____

☞ Patient's mobility limitation is such that without the use of a power mobility device, Patient would be unable to participate in one or more MRADLs within the home.

☞ **Mobility limitation:**

- Prevents patient from accomplishing MRADLs entirely; or,
- Places patient at reasonable determined heightened risk of morbidity or mortality secondary to attempts to participate in MRADLs; or
- Prevents the patient from completing the MRADLs within a reasonable time frame.

- A. Endurance: Normal Poor Other _____
- B. Cognitive abilities: Normal Poor Other _____
- C. Visual ability: Normal Poor Other _____
- D. Balance Normal Poor Other _____
- E. Is patient capable of and willing to safely operate a power mobility device? Yes No
- F. Does the patient require a mobility device for a lifetime Yes No

☞ **Justification for prescribed accessories:**

- 1. Pressure Relief Cushion: A history of (or potential for) decubitus ulcers or skin breakdown.
- 2. Reclining Back: Quadriplegia a fixed hip angle Decubitus Other _____
- 3. Elevating Leg Rests: Significant edema Unable to bend knee(s) other: _____
- 4. Adjustable Height Arm Rests: Pressure/pain relief Arm/shoulder immobility

☞ Other considerations or information relevant to the evaluation including details as presence of abnormal tone or deformity of arms or legs, absence or impairment of sensation, neck/hip/pelvic posture and flexibility?

Based upon my evaluation, this patient has mobility limitations that significantly impair the patient's ability to participate in one or more mobility related activity of daily living. The addition of a power mobility device will significantly improve this patient's ability to perform mobility related activities of daily living in the home.

Health Professional Completing This Evaluation:

Name:		Address:			
Phone#		FAX#	NPI#	UPIN#	

I am the treating physician and all medical information stated above is true and accurate to the best of my knowledge. I hereby incorporate this document to the patient's medical record and will provide additional information to Hometown Medical Supplies upon demand.

SIGNATURE: _____ **DATE:** _____

Guaranteed Low Prices

Service with Smile



FTF



Power Mobility Device (PMD) Prescription

☞ Beneficiary's Name _____ DOB: _____

☞ Face to Face Examination Date: _____

☞ Description of item(s) that is ordered. This may be general – e.g. “Power mobility device”- or may be detailed.

☞ Pertinent diagnosis/conditions that relate to the need for the Power Mobility Device (PMD):

☞ ICD 9 Codes: _____

☞ Length of Need: _____ (99 months is lifetime)

☞ Physician's Name: _____

☞ Physician's Signature: _____

☞ Office Phone number: _____

☞ Date of Signature: _____ NPI# _____

Guaranteed Low Prices

Service with Smile



FTF

Hometown Medical Supplies (408) 279-3955

4

Mobility Limitation Criteria

- Patients are prevented from accomplishing an MRADL entirely, or are at heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL.
- Patients are prevented from completing an MRADL within a reasonable time frame.
- Patient limitations cannot be sufficiently resolved with an appropriately fitted cane or walker.
- Patient does not have sufficient upper limb function to self-propel an optimally configured manual wheelchair safely in the home to perform MRADLs during a typical day. An optimally configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non powered accessories.
- Patient has limited strength, endurance, range of motion, or coordination; has presence of pain or deformity; or absence of one or both upper limbs.
- The patient has (or does not have in the case of the need for a PWC) sufficient strength, postural stability, and other physical and mental capabilities needed to operate the POV safely in the home.
- The patient's home provides (or does not provide in the case of a need for a PWC) adequate access between rooms, maneuvering space, and surfaces for the operation of a POV.
- The patient's home provides adequate access between rooms, maneuvering space, and surfaces for the operation of a PWC.
- Use of a POV or PWC will significantly improve the patient's ability to participate in MRADLs, and the patient will use it on a regular basis in the home.
- The patient has expressed willingness to use the POV or PWC in the home.

