FUNCTIONAL MOBILITY EVALUATION

FACE TO FACE EXAMINATION REPORT
DOCTOR'S NOTES

MD/PT/OT Name: _____ **NPI#:**_____

Address:_____ **City:**_____

Tel:_____ **Fax:**_____

PHYSICAL/FUNCTIONAL STATUS

PATIENTS NAME:_____ _____ SEX:_____ INSURANCE:_____ ____ PHONE:_____

ADDRESS:_____ CITY:_____ST:_____ZIP:_____

AMBULATION STATUS : YES ☐ NO ☐
NON-AMBULATORY _____

LIMITED AMBULATION _____
PATIENT REQUIRE ASISTANCE OF YES ☐ NO ☐ TO AMBULATE DISTANCE

PATIENT IS ABLE TO INDEPENDENTLY AND SAFELY AMBULATE YES ☐ NO ☐

"MOBILITY RELATED ACTIVITIES OF DAILY LIVING STATUS: status of related activities of daily living (MRADLs) with out the use of a wheelchair. Enter "X" in appropiate box for each activity. Include consideration of movement throughout the normal home enviroment to accomplish these activities in the customary. Include consideration of movement throughout the normal home enviroment to accomplish these activities in the customary of food preparation eating and other necessities."

STATUS:	INDEPENDENT	INDEPENDENT BUT WITH RISK TO SAFETY	INDEPENDENT BUT REQUIRES EXCESSIVE TIME	REQUIRES MINIMIUM ASISTANCE	REQUIRES MODERATE ASSISTANCE	REQUIRES MAXIMUM ASSISTANCE
BATHING						
DRESSING						
GROOMING						
FOOD PREPARATION						
EATING						
TOILETING						
OTHER						

WHICH CONDITIONS IMPACT THE PATIENT'S ABILITY TO AMBULATE INDEPENTLY, SAFELY, AND IN A TIMELY MANNER PARTICIPATING IN A DAILY LIVING MOBILITY RELATED ACTIVITY?

☐	DYSPNEA	☐	LOSS OF RANGE OF MOTION	☐	PAIN
☐	IMBALANCE	☐	IMPAIRED JUDGMENT	☐	COGNITIVE DEFICIT
☐	VISION/HEARING DEFICIT	☐	FATIGUE	☐	OTHER IF APPLY
☐	WEAKNESS	☐	HISTORY OF FALLS	☐	OTHER IF APPLY

RISK FACTORS: **PAIN SCALE (O-10 RATING)**

CHECK IF APPLY:

☐ BONY PREMISES	☐ NECK	☐ ELBOWS
☐ COMPROMISED CIRCULATORY STATUS	☐ BACK	☐ WRISTS
☐ IMPAIRED NUTRICIONAL STATUS	☐ BUTTOCKS	☐ FINGERS
☐ FECAL OR URINARY INCONTINENCE	☐ SHOULDERS	☐ TIPS

MUSCLE STRENGTH:

ENTER MEASUREMENTS OF MUSCLE STRENGTH IF FINDINGS ARE ABNORMAL						
STATUS:	RIGHT ARM	L/A	LEFT LEG	R/L	TRUNK	NECK
NORMAL						
ABNORMAL FINDINGS						
NO ACTIVE MOVEMENT						

COMMENTS : _____

MUSCLE TONE: ***PLACE AN "X" IN APPROPIATE BOX IN EACH COLUMN***

STATUS:	RIGHT ARM	LEFT ARM	LEFT LEG	RIGHT LEG	TRUNK	NECK
NORMAL						
HYPOTONIA/FLACIDITY						
ATHETOSIS/FLUCTUATING TONE						
MILD SPASTICITY						
MODERATE SPACITY						
SEVERE SPACITY						

COMMENTS : _____

RANGE OF MOTION:

PROVIDE ACTUAL MEASUREMENTS IN DEGREE IF FINDINGS ARE DEFICIT, MILD, SEVERE OR FIXED CONTRACTURES, OTHER WISE MARK THE BOX WITH "X" FOR NORMAL OR FUNCTIONAL.

STATUS:	SHOULDER R/L	ELBOWS R/L	WRISTS R/L	HIPS R/L	TRUNK	KNEES R/L	ANKLES R/L
NORMAL							
FUNCTIONAL							
DEGREE OF LIMITATION							
FIXED CONTRACTURES							

COMMENTS : _____

TRUNK CONTROL/ SITTING BALANCE:

- [ ] DIFFICULTY WITH SEATING BALANCE
- [ ] REQUIRES LATERAL TRUNK SUPPORT
- [ ] REQUIRES LATERAL SUPPORT OF PELVIS
- [ ] UNABLE TO SIT UPRIGHT

COMMENTS : _____

DOES PATIENT HAVE SUFFICIENT AND/ OR LESS STRENGTH AND ENDURANCE TO SELF PROPEL?

YES ☐ NO ☐

COMMENTS : _____

IF THE PATIENT IS UNABLE TO SELF PROPEL A MANUAL WHEEL CHAIR, IS THERE A CARE GIVER THAT WILL BE ABLE TO MOVE THE BASE AND PATIENT AROUND THE HOME FOR PARTICIPATION IN MOBILITY RELATED ACTIVITIES OF DAILY LIVING?

YES ☐ NO ☐

TRANSFER STATUS:

TRANSFER METHOD		TRANSFER ASSIST LEVEL
☐	STANDARD PIVOT	☐ INDEPENDENT
☐	POP-OVER	☐ MINIMAL ASSISTANCE
☐	SLIDING BOARD	☐ MODERATE
☐	MECHANICAL LIFT	☐ MAXIMUM ASSISTANCE
☐	MANUAL LIFT 1 2 3 3PERSON (CIRCLE)	

PATIENT HAS CARE GIVER	YES ☐	NO ☐
CARE GIVER IS ABLE AND WILLING TO PARTICIPATE IN THE USE OF MAE	YES ☐	NO ☐
CARE GIVER HAS LIMITATIONS	YES ☐	NO ☐
PATIENT SPENDS TIME WITH OUT CARE GIVER	YES ☐	NO ☐

MEDICAL STATUS:

CARDIO VASCULAR STATUS NORMAL _____ IMPAIRED _____

COMMENTS : _____

BLADDER DISFUNCTION CONTINENT _____ INCONTINENT _____

BOWEL DISFUNCTION CONTINENT _____ INCONTINENT _____

COMMENTS : _____

VISION STATUS:

- [ ] NOT TESTED
- [ ] NORMAL
- [ ] FUNCTIONAL WITH CORRECTION

AUDITORY STATUS:

- [ ] NOT TESTED
- [ ] NORMAL
- [ ] GOOD
- [ ] FAIR
- [ ] ABSENT
- [ ] POOR

IMPACT OF MAE USE _____

COGNITIVE STATUS:

☐ INTACT
☐ MILDLY IMPAIRED
☐ MODERATELY IMPAIRED
☐ SEVERELY IMPAIRED
☐ UNABLE TO ASSESS

IMPACT OF MAE USE _____

SKIN INTEGRITY/CONDITION:

PATIENT IS

☐ SELF POSITIONING
☐ DECREASED SELF POSITIONING STATUS
☐ NON SELF POSITIONING

PATIENT HAS

☐ NORMAL SENSATION
☐ DIMINISHED SENSATION
☐ ABSENT SENSATION LOCATION _____

COMMENTS _____

SKIN BREAK DOWN PRESENT: ☐ YES ☐ NO

STAGE _____ LOCATION _____

HISTORY OF PRESSURE ULCERS CHRONIC ☐ YES ☐ NO

COMMENTS _____

IS THE PATIENT A CANDIDATE FOR A POWER MOBILITY DEVICE? ☐ YES ☐ NO

IS A SCOOTER APPROPRIATE? ☐ YES ☐ NO

WHICH SCOOTER CONFIGURATION IS RECOMMENDED

☐ STANDARD WEIGHT CAPACITY ☐ EXTENDED WEIGHT CAPACITY

IF ANY OF THE FOLLOWING ANSWERS ARE YES, CONSIDER ANOTHER FORM OF POWER OR MANUAL MOBILITY DEVICE.

IMPAIRED TRUNK STRENGTH	☐ YES	☐ NO	IMPAIRED TRUNK BALANCE	☐ YES	☐ NO
REQUIRES TRANFER ASSIST	☐ YES	☐ NO	UPPER EXTREMITY DYSFUNCTION	☐ YES	☐ NO
DIMINISHED HAND DEXTERITY	☐ YES	☐ NO	COGNITIVE/ JUDGEMENT IMPAIRMENT	☐ YES	☐ NO
VISUAL IMPAIRMENT	☐ YES	☐ NO	HOME ACCESSIBILITY INADEQUACIES	☐ YES	☐ NO
HISTORY OD DECUBITUS	☐ YES	☐ NO	POSTURAL ABNORMALITIES	☐ YES	☐ NO

OTHER PERTINENT INFORMATION _____

IS A POWER WHEELCHAIR RECOMMENDED? ☐ YES ☐ NO

DOES THE PATIENT HAVE THE FUNCTIONAL ABILITY TO USE RECOMMENDED DRIVE CONTROL, COGNITION, VISUAL ABILITY AND JUDGMENT NECESSARY TO SAFELY OPERATE A POWER MOBILITY DEVICE TO PARTICIPATE IN MRADLs IN THEIR HOME?

☐ YES ☐ NO (IF NO, CONSIDER MANUAL MOBILITY DEVICE

WHAT WHEELCHAIR BASE CONFIGURATION IS RECOMMENDED?

☐ LIGHT DUTY USER
☐ STANDARD WEIGHT CAPACITY
☐ PROGRAMMABLE ELECTRONIC
☐ POWER SEATING ACCOMMODATION
☐ VAN STYLE STANDARD SEATING
☐ ACTIVE USER
☐ EXTENDED WEIGHT CAPACITY
☐ POSITIONING ACCESSORIES
☐ ALTERNATIVE DRIVE CONTROLS/ELECTRONICS
☐ REHAB FRAME SEATING FOR POSITIONING ACCESSOR

PHYSICIAN'S SIGNATURE _____ DATE _____