MOBILITY ASSISTIVE EQUIPMENT (MAE) EVALUATION

Date of Evaluation: ______________________

I. PATIENT INFORMATION

Name: ______________________ D.O.B.: __________ Sex.: __________

Address: ______________________ Phone: __________

Ordering Practitioner: ______________________ Phone: __________

____

II. MEDICAL INFORMATION AND HISTORY

Height: __________ Weight: __________

Diagnoses Responsible for the Mobility Limitation: ______________________ ICD10: __________

Diagnoses Responsible for the Mobility Limitation: ______________________ ICD10: __________

Diagnoses Responsible for the Mobility Limitation: ______________________ ICD10: __________

Diagnoses Responsible for the Mobility Limitation: ______________________ ICD10: __________

Describe Symptoms That Limit Ambulation:

What is the patient’s **mobility limitation** and how does it interfere with the performance of mobility-related activities of daily living (MRADLs)?

Which **MRADLs are affected** (toileting, bathing, grooming, feeding and etc)?

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Can the patient's mobility limitation(s) be sufficiently and safely resolved by the use of an appropriate fitted **CANE or WALKER**?

Yes No If no, continue.

CANE Tried and Failed OR Considered and Ruled Out

WALKER Tried and Failed OR Considered and Ruled Out

Explain and support with quantitative measurements why a CANE or a WALKER is not an option (e.g., Manual Muscle Strength Testing of BUE and BLE, ROM, deformities, pain level, shortness of breath or SAT levels, etc.):

Does the patient have sufficient upper extremity function to self-propel an optimally configured MANUAL WHEELCHAIR in the home to perform MRADLs during a typical day?

Yes No If no, continue.

MANUAL WHEELCHAIR Tried and Failed OR Considered and Ruled Out

Explain and support with quantitative measurements (e.g., Manual Muscle Strength Testing of BUE and BLE, ROM, deformities, pain level, shortness of breath or SAT levels, etc.):

Does the patient have the physical and mental abilities to transfer into a SCOOTER and to operate it safely in the home?

Yes No If no, continue.

SCOOTER Tried and Failed OR Considered and Ruled Out

Explain and support with quantitative measurements (e.g., Manual Muscle Strength Testing of BUE and BLE, ROM, deformities, pain level, shortness of breath or SAT levels and etc.):

Will the use of the SCOOTER inside the home significantly improve the patient's ability to participate in MRADLs? Please explain.

Is the patient willing to use the scooter inside the home?

Yes No

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MOBILITY ASSISTIVE EQUIPMENT (MAE) EVALUATION

Does the Patient have the physical and mental abilities to operate a POWER WHEELCHAIR safely in the home?

Yes No If no, explain:

Will the use of the POWER WHEELCHAIR inside the home significantly improve the patient's ability to participate in MRADLs? Please explain.

Is the patient willing to use the POWER WHEELCHAIR inside the home?

Yes No

Is the patient's mobility limitation due to a neurological condition, myopathy, or congenital skeletal deformity?

Yes No If yes, please elaborate:

III. CURRENT EQUIPMENT

Description of Current Equipment: ______ D.O.P: ______ Purchased By: ______

Why does the current equipmentneed to be replaced?

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IV. MEDICAL JUSTIFICATION FOR RECOMMENDED EQUIPMENT AND ACCESSORIES

BASE:
If the patient requires options and accessories that are not standard on the BASE, these items MUST BE SEPARATELY JUSTIFIED.

SEATING SYSTEM:
Skin Protection and/or Positioning Seat Cushion:

Positioning Back Cushion:

Custom Fabricated Seat Cushion and/or Back (if recommended, clearly explain why a pre-fabricated seating system is not sufficient):

Manual or Power Tilt:

Manual or Power Recline:

Manual or Power Tilt & Recline:

Detachable Height Adjustable Armrests (please justify the need for detachable feature):

Fixed Height Adjustable Armrests:

Swing Away Joystick:

Manual or Power Elevating Legrests:

Power Articulating Foot Platform:

Removable or Swing-Away Hardware (please explain for what accessory and give justification):

Additional Required Options and/or Accessories (one-arm drive, alternative drive device – such as sip-n-puff, head array or custom joystick, custom foot box, seating/positioning belts, laterals and etc.) Please see page 5 for continued medical justification.

PATIENT NAME: ______________________ DATE OF EVALUATION: ______________________

V. CONTINUATION OF JUSTIFICATIONS AND ADDITIONAL COMMENTS

VI. REVIEW AND SIGNATURE ATTESTATION

Print Therapist Name: ____________________

Therapist Signature: ____________________ Date of Signature: ____________

By signing this MAE evaluation, I have reviewed with the findings and recommendations and concur with the findings.
IF THIS MAE EVALUATION WAS PERFORMED AFTER THE PHYSCIAN'S F2F ENCOUNTER, THEN THE DATE THE PHYSICIAN CO-SIGNS THE MAE EVALUATION IS TO BE LISTED AS THE DATE OF THE F2F EXAMINATION ON THE 7 ELEMENT ORDER.

Print Ordering Physician's Name: ____________________

Ordering Physician's Signature: ____________________ Date of Signature: ____________

PATIENT NAME: ____________________ DATE OF EVALUATION: ____________