

Patient Name:

Appointment Date:

Practitioner:

Fax:

Total Pages: 5



**DIAMOND**

## ***Practitioner's 3 Easy Steps for the visit:***

1.  **Complete the**

Face-to-Face form\* and the Prescription form during the exam

2.  **Document in the chart note**

that a mobility evaluation occurred (if a mobility exam occurred during the appointment)

3.  **Fax**

- The Face to Face Examination Form
- The Prescription Form
- The Chart Notes

to **(800) 438-2048** Fax

If you have questions please call  
(800) 977-3002

**Confirmation of the prescription will follow.**

\*Practitioner has the choice on how to document the need for PMD; simply complete the attached form, download the form yourself for completion, or address all of the form questions in the patient's chart note.

## Face-to-Face Mobility Examination Report For a Power Wheelchair

Patient Information						Date of Face to Face Examination: _____					
Name:						HICN:					
Mailing Address:						Telephone:					
City:		State:		Zip:		DOB:		Age:			
Physician or Treating Practitioner Information											
Name:						UPIN:					
Mailing Address:						Telephone:					
City:				State:				Zip:			
Current Symptoms, Related Diagnosis, and History (Must Be Completed by Treating Practitioner)											
What medical conditions/diseases limit your patient's mobility in their home?											
<input type="checkbox"/> Cerebral Vascular Disease / CVA				<input type="checkbox"/> Hemiplegia/Hemiparesis				<input type="checkbox"/> Paraplegia/paresis			
<input type="checkbox"/> COPD				<input type="checkbox"/> Multiple Sclerosis				<input type="checkbox"/> Parkinson's Disease			
<input type="checkbox"/> CHF				<input type="checkbox"/> Muscular Dystrophy				<input type="checkbox"/> Renal Failure			
<input type="checkbox"/> Degenerative Joint Disease				<input type="checkbox"/> Osteoarthritis				<input type="checkbox"/> Rheumatoid Arthritis			
<input type="checkbox"/> Diabetes/Neuropathy											
<input type="checkbox"/> Other, Please describe: _____											
How do the above conditions interfere with their ability to perform Activities of Daily Living (ADLs) in their home?											
<input type="checkbox"/> Abnormality of Gait				<input type="checkbox"/> Fatigue				<input type="checkbox"/> Shortness of Breath			
<input type="checkbox"/> De-conditioning				<input type="checkbox"/> Numbness				<input type="checkbox"/> Tremor			
<input type="checkbox"/> Edema				<input type="checkbox"/> Pain				<input type="checkbox"/> Weakness			
<input type="checkbox"/> Other, Please describe: _____											
Physical Exam (Must Be Completed by Treating Practitioner)											
<b>Ht:</b>		<b>Wt:</b>		<b>B/P:</b>		<b>Pulse (resting):</b>		<b>Pulse (exertion):</b>			
<b>Shortness of Breath at Rest?</b>		<b>Shortness of Breath w/exertion?</b>		<b>Is O2 required?</b>		<b>Number of Liters?</b>		<b>O2 Sats?</b>			
Y      N		Y      N		Y      N							
<b>Any current pressure sores?</b>		<b>History of pressure sores?</b>		<b>Location?</b>		<b>Stage?</b>		<b>Able to shift weight?</b>			
Y      N		Y      N						Y      N			
<b>Poor Balance</b>		<b>Poor Endurance</b>		<b>History of Falls</b>		<b>Risk of Falls</b>		<b>Significant Edema</b>			
Y      N		Y      N		Y      N		Y      N		Y      N			
<b>Upper Body Weakness:</b>		_____ Mild		_____ Moderate		_____ Severe		<b>Gait/Pattern:</b>		_____ Non-Ambulatory	
<b>Upper Body Pain:</b>		_____ Mild		_____ Moderate		_____ Severe				_____ Max Assist	
<b>Lower Body Weakness:</b>		_____ Mild		_____ Moderate		_____ Severe				_____ Mod Assist	
<b>Lower Body Pain:</b>		_____ Mild		_____ Moderate		_____ Severe				_____ Ataxic	
<b>Contracture:</b>		RUE / LUE		RLE / LLE						_____ Shuffling	

**Face-to-Face Mobility Examination Report  
For a Power Wheelchair**

Patient Name: \_\_\_\_\_ Treating Practitioner: \_\_\_\_\_

1. Please select all of the Activities of Daily Living (ADLs) that your patient is unable to perform inside their home without the aid of powered mobility equipment.

- |   |   |
|---|---|
| <input type="checkbox"/> Feeding                  | <input type="checkbox"/> Dressing                     |
| <input type="checkbox"/> Bathing                  | <input type="checkbox"/> Toileting                    |
| <input type="checkbox"/> Grooming                 | <input type="checkbox"/> Other, Please describe _____ |
| <input type="checkbox"/> Moving from Room to Room |   |

2. Why can't a cane or walker meet this patient's mobility needs in the home?

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3. Why can't a manual wheelchair meet this patient's mobility needs in the home?

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4. How has your patient's condition changed so that they now require a Power Wheelchair to complete their ADLs?

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5. Please indicate why a Power Operated Vehicle (POV)/Scooter will not meet this patient's mobility needs in the home.

- |  |   |
|--|---|
| <input type="checkbox"/> Patient Requires Joy Stick Controller       | <input type="checkbox"/> Patient Requires Elevating Leg Rests                           |
| <input type="checkbox"/> Patient Presents Poor Trunk Stability       | <input type="checkbox"/> Patient Requires Fully Reclining Back                          |
| <input type="checkbox"/> Patient Requires Adjustable Height Armrests | <input type="checkbox"/> Patient's Home Presents Insufficient Space for Maneuverability |
| <input type="checkbox"/> Patient Unable to Safely Operate a POV      | <input type="checkbox"/> Other, Please describe _____                                   |

6. Does your patient have the physical and mental abilities to safely operate a Power Wheelchair in the home?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

7. Is your patient willing and motivated to use a power wheelchair in the home?

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

## Face-to-Face Mobility Examination Report For a Power Wheelchair

Patient Name: \_\_\_\_\_  
\_\_\_\_\_

Treating Practitioner: \_\_\_\_\_

**If you intend to prescribe a power mobility device (PMD) for your patient, you should:**

- I. Complete this form for your patient's medical record;
- II. Enter a specific chart note in the patient's medical record indicating that you have:
  - a) Conducted a Face-to-Face Examination;
  - b) Completed a Face-to-Face Mobility Evaluation Report;
  - c) Completed a Prescription for a specific PMD.
- III. Provide copies of the prescription, the report, and the chart note detailed above to the mobility device provider.

If you do not believe that the documentation listed above provides adequate support for the PMD prescription, you may provide additional supporting documentation. Additional documentation may include physician office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals, and test reports.

**NOTE:**

The Centers for Medicare and Medicaid Services (CMS) recognizes the increased documentation burden for PMDs. Therefore, code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs. The payment amount for this documentation preparation is \$21.60 in addition to the office visit. Additional information can be obtained through CMS' *MedLearn Matters Number 4121* (<http://www.cms.hhs.gov/MLN MattersArticles/downloads/MM4121.pdf>).

I certify that the information provided is a true and accurate representation of my patient's current condition and that a major reason for the visit was a mobility examination. I hereby incorporate this document into my patient's medical record.

**Physician or Treating Practitioner**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Texas Academy of Family Physicians

The Texas Academy of Family Physicians has created this form and made it available for physicians to use. It is available on their website at <http://www.tafp.org/resources/usefulForms/>.

