POWER MOBILITY DEVICES (PMDs) AND CUSTOM MANUAL WHEELCHAIRS

CERTIFICATE OF MEDICAL NECESSITY (completed by PHYSICIAN)

Patients Name_____Birth Date_____/_____/_____

Sex_____Height_____Weight_____**Diagnosis**_____

History_____

_____

Date of Onset_____/_____/_____[ ] Improving [ ] Worsening

Physician (print)_____Upin:_____Lic. #:_____

Physician's Phone [_____]_____**Face-to-Face Eval. Date**_____/_____/_____

[X]Patients condition is such that without the use of a wheelchair the patient would be bed or chair confined and:

[ ] The patient's condition is such that a manual Superstand wheelchair Model SS-1 is medically necessary.
[ ] The patient's condition is such that a power Superstand wheelchair, [ ] Model HPS-2 _ power OR
[ ] Model PS-2 full power is medically necessary, patient is unable to operate a manual wheelchair.

[ ] The patient is mentally and physically able to operate the ordered equipment safely and responsibly.
[ ] The patient has a caregiver who will operate equipment safely and responsibly.
[ ] Requested wheelchair cannot be replaced/downcoded to alternative equipment ***without standing feature.***
[ ] Patient does not have sufficient U/E function to self propel a manual wheelchair to perform MRADLs in home.
[ ] The patient's weight is satisfactory for the weight capacity of the ordered wheelchair.

[ ] The patients diagnosis/condition is such that a fitted cane/walker or scooter would not be sufficient or safe because:

_____

_____

Duration of expected wheelchair use [ ] Lifetime [ ] Other_____

Patient needs a standing wheelchair as an adjunct to therapy on a <u>daily basis</u> for the following reasons:

Improve circulation, reduce swelling in lower extremities	[ ] yes [ ] no
Provide pressure relief (independently), prevent decubitus ulcers	[ ] yes [ ] no
Help maintain and improve bone integrity	[ ] yes [ ] no
Improve bowel and urinary function and regularity	[ ] yes [ ] no
Improve range of motion and strengthen U/E and L/E and trunk	[ ] yes [ ] no
Prevent/reduce muscle spasms and contractures	[ ] yes [ ] no
Strengthen cardiovascular, enhance breathing, swallowing, digestion	[ ] yes [ ] no
Significantly improve daily living independence, improve quality of life	[ ] yes [ ] no

Patient's Prognosis:_____

Ambulation: [ ] None [ ] Limited – Distance_____ [ ] 1-PersonAssist [ ] 2-Person Assist
[ ] Needs Wheelchair for mobility

Transfer Method:_____
[ ] Independent [ ] Dependent [ ] 1-Person Assist [ ] 2-Person Assist

Arm Strength: LEFT - [ ] Normal [ ] Reduced ROM ROM_____%
RIGHT -[ ] Normal [ ] Reduced ROM ROM_____%

Leg Strength: [ ] None [ ] Reduced [ ] Normal ROM_____%

Current wheelchair: [ ] Manual [ ] Power When Obtained_____/_____/_____

Current equipment: [ ] Does not meet patients needs [ ] Does meet patients needs
[ ] Cannot be repaired to meet the patients needs

Current standing program: ____ Xs a day ____ Xs a week [ ] Assisted [ ] Non-Assisted

- MRADL = ***mobility-related activities of daily living.***

The patients diagnosis of _____, presents mobility limitations that significantly affect his/her ability to perform (1) or more MRADLs (such as toileting, bathing, feeding, dressing) independently within a reasonable timeframe and patient has the following ability rating:

[ ] Decreased MRADL ability [ ] No MRADL ability

[ ] A **manual** ***standing wheelchair*** will improve the patient's ability to perform MRADLs, and the patient has not expressed an unwillingness to use the manual wheelchair in the home.

[ ] A **power** ***standing wheelchair*** will improve the patient's ability to perform MRADLs, and the patient has not expressed an unwillingness to use the power wheelchair in the home.

***** Patient will use the Standing wheelchair approximately _____ hours per day inside and outside the home.

Homestead: [ ] Home [ ] Apartment [ ] Institution [ ] Own [ ] Rent [ ] Lives Alone [ ] Lives With Others

[ ] Home is wheelchair accessible and allows adequate maneuverability - Storage [ ] In Home [ ] Other

Transportation: [ ] Car [ ] Van [ ] Public Transportation [ ] Other_____

***** Please find enclosed a copy of the face-to-face exam report for wheelchair necessity and reports of any laboratory tests, x-rays or other diagnostic tests.

I the undersigned certify that the above information is true, that this patient requires the ordered equipment/accessories due to his/her medical condition(s), that the use of the equipment is not for the patient's comfort and convenience but is medically necessary for mobility and overall health. I also certify with my signature on their documents, that I have reviewed all information provided by the evaluating Physiatrist or Physical/Occupational Therapist (if any) and concur with or have noted my disagreements with their findings.

Ordering Physician's Signature Date