

ONE SOURCE MEDICAL SOLUTIONS, INC.

One Company. Multiple Solutions.™

MOBILITY EVALUATION - MANUAL WHEELCHAIR

Date: _____ Referred By: _____

SECTION 1. Patient Information

Name: _____ Birth Date: _____ Medicare/Insurance#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Sex: _____ Height: _____ Weight: _____

What type of environment does the patient reside in (Example: 1 story home, an apartment complex; please give full detail): _____

SECTION 2. MEDICAL HISTORY

Date or onset of condition/injury requiring use of manual wheelchair: _____

Diagnosis(es) (Please include written description and ICD-9 Codes): _____

How has the patient's condition progressed to now requiring mobility assistance: _____

Patient's Current Ambulatory Status (Please include any assistive device, physical assistance, and degree of assistance required): _____

Patient's Current Ability to Perform Activities of Daily Living in Home (please include any assistive device, physical assistance, and degree of assistance required): _____

IS THE PATIENT:

Bed confined: _____ hours per day: _____ Chair confined: _____ hours per day: _____

Present Equipment- Make: _____ Model: _____ Age of Equipment: _____

of Hours/Day in Wheelchair: _____ Est. Length of Need(# of Months, 99=lifetime): _____

Reason for Replacement: _____