ONE SOURCE MEDICAL SOLUTIONS, INC.

One Company. Multiple Solutions.™

IS THE PATIENT CAPABLE OF USING:

Standard or lightweight wheelchair within the home *(please detail)*:__________________________

____

Functional Status *(please provide quantitative measurements)*:

ROM Limitations:____

Muscle Strength Limitations:____

Upper Extremity Function:____

Lower Extremity Function:____

Ability to Transfer:____

Endurance:____

Trunk Stability:____

Section 3. Additional Question for Medical Necessity

Please assess the general systems of this patient:

Vision:

Hearing:

Communication:

Cognitive Level:

Respiratory:

Has the patient been evaluated using the wheelchair/scooter/POV in the home?________________

Can the patient safely operate the wheelchair/scooter/POV?____________________________

Where will the patient use the equipment?____

What is the benefit of a wheelchair/scooter/POV for this patient?________________________

____

I have reviewed Sections 1, 2, and 3 of this clinical assessment and agree that it is and accurate assessment of the client and the needs.

Therapist's Name:__________________________ Physician's Name:__________________________

Address:__________________________________ Address:__________________________________

Signature:____________________ Date:_______ Signature:__________________ Date:_________

License #:_________________________________ UPIN:______________NPI:_________________

1555 W. Mockingbird Lane, Suite 210
Dallas, Texas 75235
Office (214) 421-7000 Fax (214) 421-7001