ONE SOURCE MEDICAL SOLUTIONS, INC.

One Company. Multiple Solutions.™

MOBILITY EVALUATION - POWER WHEELCHAIR/SCOOTER/POV

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 power wheelchair/scooter/POV:_____

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

_____

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

_____

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 PATENT:

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:_____

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