



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

MOBILITY EVALUATION FORM

This evaluation must be completed by a New Hampshire licensed physician, occupational therapist, or physical therapist specializing in rehabilitation medicine. Evaluator must have a broad knowledge of the various seating systems and wheelchairs available in today's market. **NOTE:** Requests for standard/non-customized manual wheelchairs do not require the completion of this form by a physician or OT/PT; a rehabilitation specialist may complete the form.

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ RECIPIENT MEDICAID ID #: _____

RECIPIENT HEIGHT: _____ RECIPIENT WEIGHT: _____

PROVIDER INFORMATION

PROVIDER NAME: _____ NH MEDICAID PROVIDER #: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

TELEPHONE #: _____ FAX #: _____

DATE OF EVALUATION: ____/____/____ PLACE OF EVALUATION: _____

DIAGNOSIS (written, not ICD-9) PRIMARY: _____

SECONDARY: _____

If this recipient has had multiple seating systems in the past three (3) years, or surgical procedures are anticipated, or growth or physical deterioration may limit recipient's ability to utilize the proposed seating system for less than five (5) years, then the recipient must be evaluated for an "adjustable growth" seating system that would accommodate any foreseeable changes.

CURRENT AMBULATORY STATUS

Please address the following: Would the recipient be confined to a bed if a wheelchair were not provided? Is the recipient able to use a walker, cane, or walk with assistance? What is the distance the recipient is able to ambulate without assistance?

MEDICAL HISTORY

Please provide dates and names of recent surgical procedures and/or hospitalizations as well as other relevant information.

CURRENT SEATING SYSTEM

MAKE: _____ MODEL: _____ AGE/CONDITION: _____

IDENTIFY ANY PROBLEMS WITH CURRENT SEATING SYSTEM:

PLEASE COMMENT ON RECIPIENT'S:

VISION: _____

COGNITION: _____

ABILITY TO COMMUNICATE: _____

DAILY ACTIVITY LEVEL: _____

MOBILITY EVALUATION (STRENGTH/TONE/CONTRACTURES ETC.): _____

ANTICIPATED SURGICAL PROCEDURES/ORTHOTICS: _____

OTHER SPECIAL CONSIDERATIONS: _____

PLEASE INDICATE WHICH LESS COSTLY WHEELCHAIRS/SEATING SYSTEMS HAVE BEEN CONSIDERED AND WHY THEY WOULD NOT BE APPROPRIATE TO MEET THIS RECIPIENT'S NEEDS.

(ATTACH ADDITIONAL COMMENTS AS NECESSARY):

TO BE COMPLETED BY PERSON PERFORMING THE EVALUATION

THE FOLLOWING OPTIONS ARE MEDICALLY NECESSARY:

<u>OPTION</u>	<u>JUSTIFICATION</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
16. _____	_____
17. _____	_____
18. _____	_____

RECOMMENDED CHAIR

MAKE: _____ **MODEL:** _____

Check all that apply. Indicate N/A if not applicable:

- Will allow access to recipient's home N/A
- Will allow access to school/place of employment N/A
- Will meet van/bus/other transportation methods recipient currently needs N/A
- Will meet recipient's mobility needs N/A
- Potential growth of recipient has been taken into consideration in selecting the size of chair so that it may provide at least **five (5) years of use** N/A
- Recipient's caregivers are familiar with care /maintenance/operation of this chair N/A
- Recipient has demonstrated proficiency in the safe operation of this chair N/A
- Less costly chairs have been ruled out as inappropriate N/A
- This chair will accommodate recipient's respiratory equipment and other special needs N/A

SUMMARY / COMMENTS

Signature of licensed physician, therapist or rehab specialist (non-custom. only) completing the evaluation **Date**

Printed name of licensed physician, therapist or rehab specialist (for non custom. only) completing the evaluation

INDIVIDUALS PRESENT DURING EVALUATION:

- 1) _____ Representing/Relationship to recipient: _____
- 2) _____ Representing/Relationship to recipient: _____
- 3) _____ Representing/Relationship to recipient: _____
- 4) _____ Representing/Relationship to recipient: _____

