How to use DMEevalumate.com with limited computer access:

The practitioner can complete this checklist and have a medical assistant within their practice input the provided information into the online program. The Face-to-Face notes generated by DMEevalumate will need to be reviewed and signed by the practitioner before being sent to the preferred DME provider.

Log In

Initial Details

Required: Date of Office Visit _____ **Required**: Patient's Name _____

Required: DOB _____

History of Present Illness

Required: Enter ALL the diagnosis that impairs the patient's participation in MRADLS._____

_____

Required: Is the reason the patient is being seen today to document the need for a mobility device? Yes ☐ No ☐

Required: Is there a mobility limitation? Yes ☐ No ☐

Required: Would the use of a mobility assistive device improve the patient's ability to participation in MRADLS and does the patient need the equipment for use on a regular basis in the home? Yes ☐ No ☐

What in-home MRADLS (Mobility Related Aids to Daily Living) is the patient currently NOT ABLE to accomplish in a timely manner and safely?

Required: **Accessing the toilet:** ☐ Timely ☐ Safely ☐ Independently ☐Other_____

Required : Accessing the kitchen (food and drink): ☐ Timely ☐ Safely ☐ Independently ☐Other_____

Required: **Moving from room to room:** ☐ Timely ☐ Safely ☐ Independently ☐Other_____

HISTORY OF PRESENT CONDITION/ RELEVANT PAST HISTORY

Required: Symptoms that limit ambulation: *(check all that apply)*: ☐Abnormal gait ☐Stumbling ☐ Falling ☐ Instability ☐ Weakness/Fatigue ☐Shortness of breath ☐ Balance ☐Other_____

Required: Symptoms have been present for: ☐1 - 2 months ☐ 3 - 6 months ☐1 year ☐More than a year

Required: Have ambulation limitations increased over time? Yes ☐ No ☐ Other _____

FALLS

Required: Does the patient have a history of falling? Yes ☐ No ☐ How Frequently _____

List any Complications from falling: *(i.e. fx hip, fx arm hospitalization)*_____

SOCIAL

Required: Prior to their mobility deficit, please select the activities the patient participated in; in their home on a regular basis *(check all that apply)* ☐Laundry ☐ Housecleaning ☐ Exercise ☐Preparing Meals ☐ Interactions with other people ☐ Other_____

Required: As a result of the mobility limitations, what does the patient do during a typical day? *(check all that apply)* ☐Reading ☐Television viewing ☐ Lying in bed ☐ Hobbies ☐Interactions with other people ☐ Other:_____

Required: Percentage of time spent sitting at home _____%

List impairment(s) that have interfered with the patient's ability to independently initiate, sustain, or complete activities: _____

Check Patient Status:

Required: Dressing ☐Without help ☐ With help ☐ Unable
Required: Bathing/ Shower ☐Without help ☐ With help ☐ Unable
Required: Preparing meals ☐Without help ☐ With help ☐ Unable
Required: Shopping for groceries ☐Without help ☐ With help ☐ Unable
Required: Doing housework ☐Without help ☐ With help ☐ Unable Done by Caregiver
☐Unable - Done by Third-party service ☐ Not being completed

Required: Doing laundry ☐Without help ☐ With help ☐ Unable Done by Caregiver
☐Unable - Done by Third-party service ☐ Not being completed

Required: Patient's Lives in?(☐House ☐Mobile Home ☐ Apartment ☐ALF ☐Other _____
Lives with? ☐family ☐With caregiver ☐Alone ☐ Other _____

Required: Does the residence provide adequate space to maneuver a power mobility device within? Yes ☐ No ☐
☐Unknown -*Will defer to equipment provider to perform home assessment*

Other Medical History

ASSISTIVE DEVICES

Required: Has the patient used a cane? Yes ☐ No ☐

Required: Has the patient used a walker? Yes ☐ No ☐

Required: Symptoms that limit ambulation/preclude the use of a cane or walker: *(check all that apply)*
☐ Shortness of breath ☐Wheezing ☐ Heart palpitation ☐ Chest pain ☐ Leg cramps
☐ Joint stiffness ☐Muscle pain ☐Muscle weakness ☐Dizziness ☐ Fear of falling

Pain in: ☐ Hip(s) ☐Hand(s) ☐Wrist(s) ☐ Knee(s) ☐ Shoulder(s) Feet

Numbness in: ☐Leg(s) ☐Feet ☐Hand(s) ☐Other_____

Required: Is the patient able to safely, and in a timely manner, complete MRADLS using a cane or walker?
Yes ☐ No ☐ Other _____

Has the patient ever had, or do they currently have a power wheelchair or scooter? Yes ☐ No ☐

YES: Which Type of Equipment: ☐Power Wheelchair ☐Scooter

How old is the power wheelchair or scooter? ☐Less than 5 years * ☐ 5 years ☐ 6-7 years ☐8-9 years ☐10+ years
** Please note that most insurance will not consider the replacement of mobility equipment that is less than 5 years old.*

Has it broken down recently? Yes ☐ No ☐

Is it broken now? Yes ☐ No ☐

According to the patient are their ambulatory challenges getting worse? Yes ☐ No ☐
Additional/Other: _____

Per patient reporting, are they finding it increasingly difficult to complete tasks independently? Yes ☐ No ☐
Additional/Other: _____

Has the patient experienced unknown weight changed in the past three months? Yes ☐ No ☐

Vital Signs

Required: Weight (pounds) ____ **Required**: Height (inches) _____ **Required**: Temperature (Fahrenheit) _____
Required: Pulse _____ **Required**: BP (XXX/XXX) _____ **Required**: Reading type ☐ Manual ☐ Auto
Required: Respirations _____

Physical Examination

Required: Sex – ☐Male ☐ Female

Required: Age - ☐Appears stated age ☐Appears younger than stated age ☐ Appears older than stated age

Required: General appearance: *(check all that apply)*
☐ Comfortable - no distress ☐Restless ☐ Well-nourished ☐Undernourished ☐ Inattentive ☐ Paled
☐ Dyspenic ☐ Well-developed ☐Other_____

Alert and oriented: ☐1 (person) ☐ 2 (person & place) ☐ 3 (person, place & time) ☐4 (person, place, time & event)☐Other _____

Skin color: ☐Normal ☐Pale ☐ Cyanotic ☐Other _____
Skin moisture: ☐Normal ☐ Abnormal ☐ Additional/Other: _____
Skin texture: ☐Normal ☐ Abnormal ☐ Additional/Other: _____
Skin other: _____
Does the patient have Decubitus ulcer/pressure sores? (Location and size) Describe: _____
_____

CARDIOVASCULAR

Reported problems *(check all that apply)* ☐Heart palpitations☐ Chest pain☐ Dizziness ☐ Other_____

RESPIRATORY

Required: Is patient on home O2: Yes ☐ No ☐

YES:, Liters Per Minute _____ Hour Per Day _____
Has the liter flow been increased to minimize dyspnea? Yes ☐ No ☐

Minutes of rest patient requires to recover from ambulation to attempt next task: _____

NEUROLOGICAL

To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over household distances to carry out activities of daily living; cooking, cleaning, hygiene, toileting etc. Independently ambulate from room to room within their home with or without the assistance of a walking device

Required: Distance patient is able to independently ambulate continuously without stopping *(check one)*

☐Patient is unable to ambulate any distance ☐ Less than 5 feet
☐No greater than 5-10 feet ☐No greater than 11-15 feet
☐No greater than 15-20 feet ☐No greater than 20-25 feet
☐ No greater than 25-30 feet ☐Greater than 50 feet

GAIT

Required: Walking during the examination *(to, from, during)* ☐ Assisted ☐Dependent ☐Independent
☐Pushed in a wheelchair ☐Other _____

Gait dysfunction *(check all that apply)*
☐Pain, weakness, and numbness that occurs during walking and lessens during sitting
☐Difficulty initiating walking ☐Trunk instability (sways) ☐ Leaning forward during walking
☐ Step asymmetry ☐ Step discontinuity ☐ Step length or height abnormalities
☐Other_____

Rest time in minute's patient required to recover from ambulation: _____
Required: Standing from a seated position: ☐Assisted ☐ Dependent ☐Independent ☐Other _____

MUSCULOSKELETAL

If one of the mobility limitations are joint related or back/disc disease related, i.e., DJD, DDD, Rheumatoid arthritis, Osteoarthritis, Osteoporosis. Medicare and most insurance companies require the affected joints (area) be examined and findings recorded.

Shoulders: Swelling RT ☐/ LT ☐ Warmth RT ☐/ LT ☐ Redness RT ☐/ LT ☐ Tenderness RT ☐/ LT ☐ Other:_____

Elbows: Swelling RT ☐/ LT ☐ Warmth RT ☐/ LT ☐ Redness RT ☐/ LT ☐ Tenderness RT ☐/ LT ☐ Other:_____

Wrist/hands: Swelling RT ☐/ LT ☐ Warmth RT ☐/ LT ☐ Redness RT ☐/ LT ☐ Tenderness RT ☐/ LT ☐ Other:_____

Hips: Swelling RT ☐/ LT ☐ Warmth RT ☐/ LT ☐ Redness RT ☐/ LT ☐ Tenderness RT ☐/ LT ☐ Other:_____

Knees: Swelling RT ☐/ LT ☐ Warmth RT ☐/ LT ☐ Redness RT ☐/ LT ☐ Tenderness RT ☐/ LT ☐ Other:_____

Ankle/feet: Swelling RT ☐/ LT ☐ Warmth RT ☐/ LT ☐ Redness RT ☐/ LT ☐ Tenderness RT ☐/ LT ☐ Other:_____

Back: ☐Scoliosis ☐Kyphosis ☐Lordosis ☐Other_____

PAIN (0 - None, 2 - mild, 5 - moderate, 8 - severe, 10 - worst possible pain) If Reported

	Right	Left		Right	Left
Shoulders	___/10	___/10	Elbows	___/10	___/10
Wrist/ hands	___/10	___/10	Hips	___/10	___/10
Knees	___/10	___/10	Ankle/ Feet	___/10	___/10
Back	___/10	___/10			

**When the diagnosis of pain is the primary factor contributing to the patient's functional impairment and is affecting their ability to perform basic MRADLS, laboratory findings must show the existence of a medically determinable impairment(s) that could reasonably be expected to produce the pain. * Include copies of the lab reports to the equipment provider to support medical necessity.*

STRENGTH AND MOTION

Required: Has the patient had a CT scan, MRI or other test that confirms the diagnosis and/or authenticates the mobility limitation: Yes ☐ No ☐

MMT (Manual Muscle strength): Muscle strength is often rated on a scale of 0/5 to 5/5 as follows: 0/5: no contraction 1/5: muscle flicker, but no movement 2/5: movement possible, but not against gravity (test the joint in its horizontal plane) 3/5: movement possible against gravity, but not against resistance by the examiner 4/5: movement possible against some resistance by the examiner (sometimes this category is subdivided further into 4-/5, 4/5, and 4+/5) 5/5: normal strength.
ROM (Range of Motion): Motions are described as active or passive. Active motion is the patient's movement of the joint through a specified arc of motion. Passive motion is the examiner's movement of the joint through a special fled arc of motion. All motions of a joint are measured from defined zero starting point positions. The degrees of motion of a joint are added in the direction the joint moves from the zero starting position.
Upper extremities Strength of 4-/5 or below cannot sustain self-propulsion in an optimally configured manual wheelchair. The patient must be capable of sustaining such functions as reaching, pushing, pulling and grasping, to accurately measure upper extremities strength. **WFL = Within Functional Levels, BFL = Below Functional Levels**

Required: Wrist extension and hand abduction: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Required: Wrist grip strength: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Required: Elbow flexion: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Required: Elbow extension MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Required: Arm abduction at shoulder: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable

Lower extremities Strength of 4-/5 or below cannot sustain effective ambulation. Muscular strength of hip flexion is more important in performing MRADLS than other muscles of the lower extremities. Muscle strength below 4-/5 result in, but are not limited to, the inability to walk at a reasonable pace without resting, inability to walk on uneven or textured surfaces and the inability to climb a few steps with the use of a single hand rail.

Required: Hip flexion: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Quadriceps: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Hamstrings: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Ankle dorsiflexion: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable
Plantar flexion: MMT: Right (0/5 – 5/5) __/5 Left __/ 5 ROM: WFL BFL Unable

Required: Standing tolerance: (Check one)

- ☐ Unable
- ☐ Poor, less than 3 minutes **without** support
- ☐ Poor, max 3-5 minutes **without** support
- ☐ Fair, max 5-10 minutes **without** support
- ☐ Good, max 10-20 minutes **without** support
- ☐ Poor, less than 3 minutes **with** support
- ☐ Poor, max 3-5 minutes **with** support
- ☐ Fair, max 5-10 minutes **with** support
- ☐ Good, max 10-20 minutes **with** support

Required: Sitting balance: ☐ WFL ☐ Min support ☐ Mod support ☐ Unable
Required: Standing balance: ☐ WFL ☐ Min support ☐ Mod support ☐ Unable

Medication currently prescribed for the symptoms limiting ambulation (only) _____
_____

CHANGE IN CONDITION
Has the progression of the disease affected the ROM in the:
Shoulders: Yes ☐ No ☐ Additional/Other: _____
Wrists: Yes ☐ No ☐ Additional/Other: _____
Other areas of the body that have been impacted by the disease progression: _____

Required: Does the patient's condition prohibit the patient's ability to self-propel a manual wheelchair? i.e. being at risk of shoulder/wrist injuries, respiratory issues, skeletal deformities etc, due to the repetitive stress required to self-propel? Yes ☐ No ☐

Is the patient missing one or both of their upper extremities? Yes ☐ No ☐

If the patient has/had a manual wheelchair, did repetitive stress injuries lead to loss of function, which has resulted in the loss of ability to self-propel an optimally configured manual wheelchair? Yes ☐ No ☐

Mental Status

Required: The patient has expressed willingness to use a power mobility device: Yes ☐ No ☐

Required: The patient has the capacity to understand how to use the device: Yes ☐ No ☐

Required: A power mobility device would assist in performing personal care tasks independently Yes ☐ No ☐

Required: Are there other limitations that would prevent the patient from operating the power mobility device safely in the home: Yes ☐ No ☐

Capacity

Required: Does the patient have the upper extremity control / strength to operate a scooter? Yes ☐ No ☐

Required: Does the patient have the shoulder limitation that would prohibit the arms to be unsupported for any length of time? Yes ☐ No ☐

Required: Is the patients grip strength adequate to compress and hold down the controls of a scooter for an extended length of time? Yes ☐ No ☐

Required: Can the patient safely stand up from a seated position without assistance? Yes ☐ No ☐

Length Of Need

Required: The inability to ambulate effectively is expected to last:

☐ Less than 6 months (must be <6 months) ☐ Lifetime = 99 months ☐ Indefinitely