

POWER MOBILITY DEVICES (PMDs) AND CUSTOM MANUAL WHEELCHAIRS

CERTIFICATE OF MEDICAL NECESSITY (completed by PHYSICIAN)

Patients Name _____ Birth Date ____/____/____

Sex _____ Height _____ Weight _____ **Diagnosis** _____

History _____

Date of Onset ____/____/____ [] Improving [] Worsening

Physician (print) _____ Upin: _____ Lic. #: _____

Physician's Phone [_____] **Face-to-Face Eval. Date** ____/____/____

[X] Patients condition is such that without the use of a wheelchair the patient would be bed or chair confined and:

- [] The patient's condition is such that a manual Superstand wheelchair Model SS-1 is medically necessary.
- [] The patient's condition is such that a power Superstand wheelchair, [] Model HPS-2 _power OR [] Model PS-2 full power is medically necessary, patient is unable to operate a manual wheelchair.

- [] The patient is mentally and physically able to operate the ordered equipment safely and responsibly.
- [] The patient has a caregiver who will operate equipment safely and responsibly.
- [] Requested wheelchair cannot be replaced/downcoded to alternative equipment ***without standing feature.***
- [] Patient does not have sufficient U/E function to self propel a manual wheelchair to perform MRADLs in home.
- [] The patient's weight is satisfactory for the weight capacity of the ordered wheelchair.

[] The patients diagnosis/condition is such that a fitted cane/walker or scooter would not be sufficient or safe because:

Duration of expected wheelchair use [] Lifetime [] Other _____

Patient needs a standing wheelchair as an adjunct to therapy on a daily basis for the following reasons:

- Improve circulation, reduce swelling in lower extremities [] yes [] no
- Provide pressure relief (independently), prevent decubitus ulcers [] yes [] no
- Help maintain and improve bone integrity [] yes [] no
- Improve bowel and urinary function and regularity [] yes [] no
- Improve range of motion and strengthen U/E and L/E and trunk [] yes [] no
- Prevent/reduce muscle spasms and contractures [] yes [] no
- Strengthen cardiovascular, enhance breathing, swallowing, digestion [] yes [] no
- Significantly improve daily living independence, improve quality of life [] yes [] no

Patient's Prognosis: _____

Ambulation: [] None [] Limited – Distance _____ [] 1-Person Assist [] 2-Person Assist
[] Needs Wheelchair for mobility

Transfer Method: _____
[] Independent [] Dependent [] 1-Person Assist [] 2-Person Assist

Arm Strength: LEFT - [] Normal [] Reduced ROM ROM _____ %
RIGHT - [] Normal [] Reduced ROM ROM _____ %

Leg Strength: [] None [] Reduced [] Normal ROM _____ %

Current wheelchair: Manual Power When Obtained ____/____/____

Current equipment: Does not meet patients needs Does meet patients needs
 Cannot be repaired to meet the patients needs

Current standing program: ____ Xs a day ____ Xs a week Assisted Non-Assisted

- MRADL = *mobility-related activities of daily living*.

The patients diagnosis of _____, presents mobility limitations that significantly affect his/her ability to perform (1) or more MRADLs (such as toileting, bathing, feeding, dressing) independently within a reasonable timeframe and patient has the following ability rating:

Decreased MRADL ability No MRADL ability

A **manual standing wheelchair** will improve the patient's ability to perform MRADLs, and the patient has not expressed an unwillingness to use the manual wheelchair in the home.

A **power standing wheelchair** will improve the patient's ability to perform MRADLs, and the patient has not expressed an unwillingness to use the power wheelchair in the home.

* Patient will use the Standing wheelchair approximately _____ hours per day inside and outside the home.

Homestead: Home Apartment Institution Own Rent Lives Alone Lives With Others

Home is wheelchair accessible and allows adequate maneuverability - Storage In Home Other

Transportation: Car Van Public Transportation Other _____

* Please find enclosed a copy of the face-to-face exam report for wheelchair necessity and reports of any laboratory tests, x-rays or other diagnostic tests.

I the undersigned certify that the above information is true, that this patient requires the ordered equipment/accessories due to his/her medical condition(s), that the use of the equipment is not for the patient's comfort and convenience but is medically necessary for mobility and overall health. I also certify with my signature on their documents, that I have reviewed all information provided by the evaluating Psychiatrist or Physical/Occupational Therapist (if any) and concur with or have noted my disagreements with their findings.

Ordering Physician's Signature

Date