Horizon
Horizon NJ Health

Date of Request: ____________________

In place of this form, you can submit Authorization Requests online securely via NaviNet. If you are not registered, please visit NaviNet.net and click *Sign Up* or call NaviNet Customer Care at 1-888-482-8057.

Mobility Evaluation Report for Power Scooter

DME Fax: 1-609-583-3023
DME Phone: 1-800-682-9094 x81017

Is this the: □ **Initial** □ **Replacement** **Reason:** ____________________

Member Name: ____________________ **Member ID #:** ____________ **DOB:** ____________

DME Provider: ____________________ **DME Provider Contact Name:** ____________________

DME Provider Contact Phone #: ____________________ **DME Provider Contact Fax# :** ____________________

Current Symptoms, Related Diagnosis and History

(Must be completed by treating practitioner)

What medical conditions/disease limits your patient's mobility in his/her home?

- □Cerebral Vascular Disease/CVA
- □COPD
- □CHF
- □Degenerative Joint Disease
- □Diabetes/Neuropathy
- □ Hemiplegia/Hemiparesis
- □'Multiple Sclerosis
- □'Muscular Dystrophy
- □ Osteoarthritis
- □ Other, Please Describe: ____________________
- □ Paraplegia/Paresis
- □ Parkinson's Disease
- □ Renal Failure
- □ Rheumatoid Arthritis

How do the above conditions interfere with their ability to perform Activities of Daily Living (ADLs) in their home?

- □Abnormality of Gait
- □De-Conditioning
- □Edema
- □Fatigue
- □Numbness
- □Pain
- □Shortness of Breath
- □Tremor
- □Weakness
- □Other, Please Describe: ____________________

Physical Exam

(Must be completed by treating practitioner)

Ht:	Wt:	B/P:	Pulse: ______ (Resting):	Pulse: ______ (Exertion)
Shortness of Breath at Rest? Y N	Shortness of Breath w/ exertion? Y N	Is O^2 required? Y N	Number of Liters?	O^2 Stats?
Any current pressure ulcers? Y N	History of pressure ulcers? Y N	Locations?	Stage?	Able to shift weight? Y N
Poor Balance? Y N	Poor Endurance? Y N	History of Falls? Y N	Risk of Falls? Y N	Significant Edema? Y N

Upper Body Weakness: ______Mild______Moderate______Severe	Gait Pattern: ______Non-Ambulatory
Upper Body Pain: ______Mild______Moderate______Severe	______Max Assist
Lower Body Weakness: ______Mild______Moderate______Severe	______Mod Assist
Lower Body Pain: ______Mild______Moderate______Severe	______Ataxic
Contracture: RUE/LUE	______Shuffling

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Member Name:____Member ID #:__________________________

1. **Please select all of the Activities of Daily Living (ADLs) that your patient is unable to perform inside his/her home without the aid of powered mobility equipment.**

   ☐Feeding ☐Dressing
   ☐Bathing ☐Toileting
   ☐Grooming ☐Other, Please Describe:______________________________
   ☐Moving Room to Room

Why can't a cane or walker meet this patient's mobility needs in the home?______________________________

____

____

2. **Why can't a manual wheelchair meet this patient's mobility needs in the home?**

____

3. **Describe how your patient's condition has changed so that he/she now requires a Scooter to complete ADLs**.

____

____

4. **Does your patient have the ability to sit erect?**
   ☐Yes ☐No

5. **Does your patient have the physical and mental abilities for safely operate a Scooter in the home?**
   ☐Yes ☐No

6. **Is your patient willing and motivated to use a Scooter in the home?**
   ☐Yes ☐No

7. **Does patient require a bariatric or heavy duty Scooter?**
   ☐Yes ☐No

8. **Is patient participating in a weight reduction program?**
   ☐Yes ☐No

I certify that the information provided is a true and accurate representation of my patient's current condition.
I hereby incorporate this document into my patient's medical record.

Signature:____***Date:***____________________
Physician or Treating Practitioner