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 Wheelchair

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
□Other, Please Describe: _____
□Fatigue
□Numbness
□Pain
□Shortness of Breath
□Tremor
□Weakness

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
Upper Body Pain: _____ Mild _____ Moderate _____ Severe
Lower Body Weakness: _____ Mild _____ Moderate _____ Severe
Lower Body Pain: _____ Mild _____ Moderate _____ Severe
Contracture: RUE/LUE

Gait Pattern: _____ Non-Ambulatory
_____ Max Assist
_____ Mod Assist
_____ Ataxic
_____ Shuffling

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Date of Request: _____

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
   - □Bathing
   - □Grooming
   - □Moving Room to Room
   - □Dressing
   - □Toileting
   - □Other, Please Describe: _____

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