

Mobility Assistive Equipment (MAE)

Patient: _____ Date of Birth: _____

(Please fill out the form regarding the requesting Mobility Aid)

1. What is the limitation of mobility (impairment of ambulation) that requires an assistive device? _____

2. Are there other type of limitations related to MRADLs that patient has that need to be addressed, if so can these limitations be compensated by other means (cognitive- vision etc) _____

3. Can the patient use a cane for ambulation to complete MRADLs due to condition(s) causing impaired ambulation and is he/she able to use the cane safely? _____

***** *If YES STOP, order cane, crutch* *****

4. OR - Does he/she require a walker for increased stability & security not provided with a cane and can he/she complete MRADLs with the use of a walker? _____

***** *If YES STOP, order walker* *****

5. Can the patient self propel in any type of manual wheelchair & is he/she safe with use of a manual wheelchair? _____

Does the wheelchair fit the patient and his/home environment? _____

6. Is a caregiver available, willing and able to push the manual wheelchair if the patient is not? _____

***** *If YES STOP, order manual wheelchair* *****

7. If the patient is unable to use a manual wheelchair of ANY type and has no assistance to push him/her: Is the patient safely able to operate a POV (Scooter)? _____

Will the POV fit the patients' functional needs and can be used within his or her usual environment? Future needs been addressed? _____

***** *If YES STOP, order scooter* *****

8. Is patient able to safely use the power wheelchair? Does the power wheelchair fit the patient and his/her usual environment & has future needs been addressed? _____

***** *If YES STOP, order power wheelchair* *****

Drs. Signature: _____ Date: _____

Please provide chart notes to support medical necessity!

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