7 Element Order

A physician may only write a prescription must contain the following seven elements:

1-Beneficiary's name

2-Description of the item that is to be ordered. This may be general e.g, "power operated vehicle(POV)," "power wheelchair," or "power mobility device" - or may be more specific.

3-Date Of completion or the face-to-face examination

4.peainent diasno'is/conditions that relate to the need for the POV or power wheelchair

5-length Of need

6-Physician's signature and date

7-Physician's NPI Number

The order needs to be filled out in the physician's hand writing throughout the order.

Must have Progress Notes & Chart Notes

Patient Name:	Physician Name:
Address:	Location:
Phone#:	Phone#:
DOB:	
Height:	Weight:

Date of face to face: ______________________________

Requested Durable Medical Equipment:	
Diagnosis Code (ICD-10)(Must have code and name spelled out):	
Length of Time Equipment Needed (Must be spelled out):	
Physician Signature:	**Signature Date:**
Physician NPI#:	

Mobility Assistive Equipment - Face to Face Examination Report

Patient Information:					
Name					**Medicare (HICN)#:**
Mailing Address:					**Telephone:**
City:	**State:**	**Zip:**	**DOB:**	**Age:**	**SSN:**
Physician or Treating Practitioner Information					
Name					**Date of last visit:**
Mailing Address:					**Telephone:**
City:		**State:**			**Zip:**

Current Symptoms Related Diagnoses and History
Please describe the reason for this mobility evalution
Please list previously diagnosed conditions that relate to the current office visit

Physical Exam				
Ht:	Wt:	B/P:	Pluse (resting):	Respiratory ○ Normal ○ Labored at times Is O_2 required?: ○ Y ○ N
Any current pressure sores? ○ Y ○ N	Location ? ____________________			
Poor Balance: ○ Y ○ N	History or Risk of Falls: ○ Y ○ N		Poor Endurance: ○ Y ○ N	
Cachexia (servere weakness): ○ Y ○ N	Obesity: ○ Y ○ N		Significant Edema: ○ Y ○ N	
Holds to furniture/walls for mobility: ○ Y ○ N				
Neck,Trunk and Pelvic Posture and Flexibility: ____ Good ____ Limited ____ Serverly Limited				

Mobility Assistive Equipment - Face to Face Examination Report

Functional Assessment			
	Question	Your Answers below must be justified by your narrative responses.	
1.	Does your patient have a mobility limitation that impairs participation in mobility Required Activities of Daily Living (MRADLs) in the home ?	○ YES ○ NO	Go To Question 2 STOP - NO MAE
2.	Can their limitations be compensated by the addition of MAE to improve the ability to participate in MRADLs in the home ?	○ YES ○ NO	Go To Question 3 STOP - NO MAE
3.	Is your patient or their caregiver capable and willing to operate the MAE safety in the home ?	○ YES ○ NO	Go To Question 4 STOP - NO MAE
4.	Can their mobility deflict be safety resolved by a cane or walker ?	○ YES ○ NO	STOP - ORDER CANE OR WALKER GO TO QUESTION 5
5.	Does your patient's home environment support use of a wheelchair or POV ? (Home assessment to be completed by Medical Equipment Supplier)	○ YES ○ NO	GO TO QUESTION 6 STOP - NO MAE
6.	Does your patient have the upper extremly function to safety propel a manual wheelchair to participate in MRADLs in the home ?	○ YES ○ NO	STOP - ORDER MANUAL WHEELCHAIR GO TO QUESTION 7

7.	**Does your patient have sufficient and trunk stability to operate a POV in the home ?**	◯ **YES** ◯ **NO**	**GO TO QUESTION 8** **GO TO QUESTION 9**
8.	**Is your patient able to safely manueuver a POV in their home ?**	◯ **YES** ◯ **NO**	**GO TO QUESTION 8** **GO TO QUESTION 9**
9.	**Does your patient need the additional features (i.e. optimal maneuverability, ease of use, upgradable/adaptable seating etc.) of a power wheelchair to participate in MRADLs in the home.?**	◯ **YES** ◯ **NO**	**Go To Question 10** **STOP - NO MAE**
10.	**Is your patient safe and able to maneuver a power wheelchair in the home ?**	◯ **YES** ◯ **No**	**STOP - ORDER PWC** **STOP**

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. This document is supported by additional medical records in my patient's file.

Physician or Treating Practitioner Signature: ________________________ **Date:-** ________________________

Need patients chart notes.