Easy as 1 2 3!

3 EASY STEPS
for
POWER MOBILITY DOCUMENTATION

Step 1: Schedule an appointment with your patient

Chart note must include:

- The major reason for the visit is for a mobility examination
- Type of activities the patient has trouble accomplishing and why (feeding, dressing, grooming, toileting, bathing, etc.)
- Include if these activities are affected *entirely,* or unable to be performed *safely,* or in a *timely* manner
- Description of the functional mobility limitations
    - Pain, weakness, ROM, etc.
    - Applicable diagnosis
    - Brief history of progression

Refer patient to a PT/OT for the *Functional Mobility Assessment*

Step 2: Prescription (written after face to face encounter conducted)

Must include patient's name, date of face to face examination, pertinent diagnoses that relate to the need for the POV or PWC, description of the item ordered, length of need, treating provider’s signature, providers NPI number, date of provider’s signature

Step 3: Fax Prescription and Copy of Chart Note to:

Johns Hopkins Pharmaquip— **410 282 8455**

Johns Hopkins Pharmaquip

410-288-8955

For Educational Purposes Only

OFFICE NOTE

CHIEF COMPLAINT: *Mobility Evaluation*

HPI: This is a 42-year-old female who has a history of CVA and right hemiplegia, who is here today for an evaluation for a powered wheelchair.

Her weight today is 164 pounds. Height is 63 inches.

1. A medical condition, limiting her ability to participate mobility-related activities of daily living, CVA with resulting right-side hemiplegia.
2. Impaired MRADLs in the home; moving from room to room, *toileting, dressing and bathing*.
3. A cane or walker is not able to meet this patient's needs, because she does have an *unsafe*, unsteady gait, with *history of falls*; about 1 fall per month. She also has insufficient upper extremity strength to use a cane or walker. She has virtually *no strength in the right arm and limited strength in the left arm*. She also has neurological conditions, including poor balance, as a result of her CVA.
4. A manual wheelchair cannot meet her mobility needs. She is *unable to propel* a manual wheelchair, due to limitations of strength and endurance, limited use of her right arm, weakness in grip in her right arm, and neurological deficits, caused by a stroke, including right-side hemiplegia.
5. If a powered wheelchair is provided; *POV/scooter, will not meet her needs* because she lacks sufficient strength and postural stability to operate the tiller of a POV; because she has a right hemiplegia, she is unable to steer, and the frontal obstruction of the scooter would make it more difficult for her to perform MRADLs.
6. The patient does have physical and mental abilities to operate a powered wheelchair safely in the home. She has near full use of her left arm and she is cognitively intact.
7. The patient is willing and motivated to use a powered wheelchair.

Her weight today is documented at 164 pounds. The width of her buttocks is 17 inches. Length from the back of the buttocks to the popliteal fossa, while seated, is 20 inches. Length from the buttocks to the anterior portion of the knee, while seated, is 24 inches.

Today we conducted an office visit for the sole purpose of *mobility evaluation*, for the use of a powered wheelchair; which I believe is in the best interest of this patient, for both her independence and safety.

______________________________ __________________

Physician's Name Date

Johns Hopkins Pharmaquip
410-288-8955

POWER MOBILITY DEVICE 7 ELEMENT ORDER

5901 Holabird Avenue, Suite A
Baltimore, MD 21224
410-288-8150
Fax: 410-282-8455

Patient Name: (Last, First)	Address: (include zip code)	Contact Phone:
Primary Insurance: Policy #	Secondary Insurance: Policy # ______	Date of Birth: Height Weight

Diagnosis icd-10:	Length of Need: ***(99 = Lifetime)***	Anticipated Start of Care___/____/_____

Check the appropriate boxes to prescribe equipment and/or supplies. If deleting any supply, indicate and initial**

Date of Face to Face Examination:__________________

Power Wheelchair

Motorized Scooter

Physician Name:	Address:	fax # ()
Physician Signature:	**NPI#**	**Date**

This form must be signed and dated by the prescribing physician before the therapy/equipment may be considered for payment. Physician's signature certified that the above represents his judgment of the patient's need for the therapy/equipment.