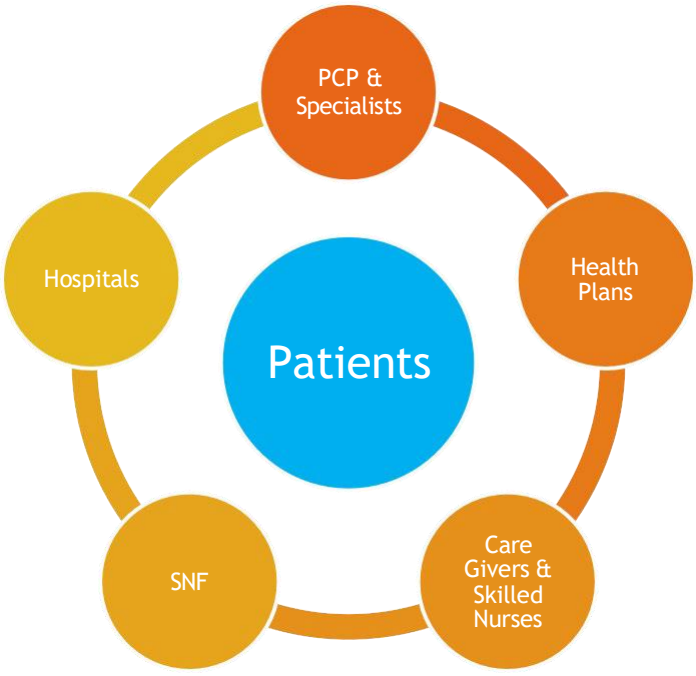
INTEGRATED
HOME CARE SERVICES

Referral Source

QUICK REFERENCE GUIDE



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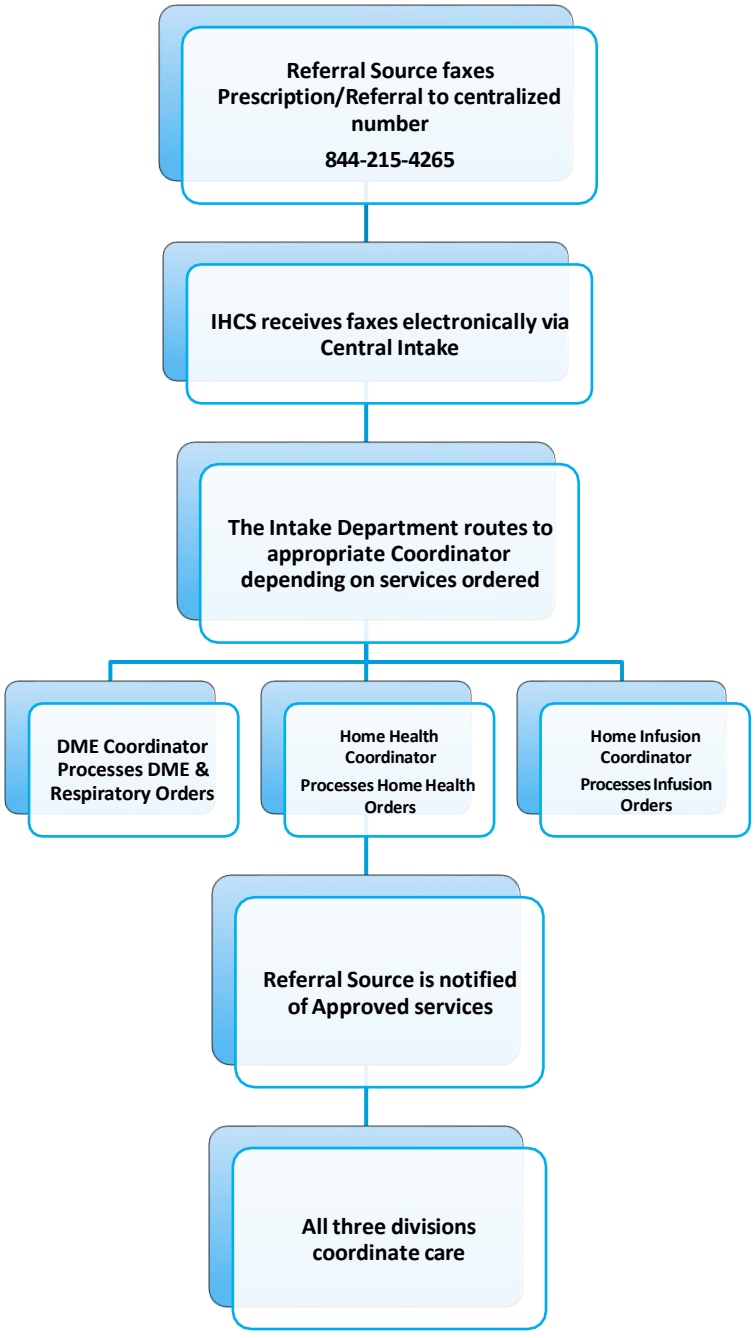
INTEGRATED HOME CARE SERVICES

Delivery System Process Flow



What is a Complete Order / Prescription?

A complete order is one that includes ALL necessary information to allow IHCS to provide the ordered service(s) to the member.

MD, DO, APRN, or PA must sign all orders; must be legible; and must include the following:

- Member Information
- Complete Name
- Member Health Plan & ID Number
- Date of Birth
- Gender
- Complete Address, City, and Zip Code
- Phone Number
- Allergies, Disability Status, Height, Weight, or Diabetic Status
- Diagnosis and Diagnosis Code(s)

Delivery Location

- Hospital Name, Admit Date, Discharge Date
- Hospital Discharge – need current "homebound" information, address, and phone number (indicate patient or relative)

Referring MD Information:

- Group Name and Referring MD Name
- NPI Number
- Backline Phone and Fax Number, including the area code

Start Date of Service

Clear and Specific written orders – examples will follow

Clinical Documentation

Ordering Physician Preferred Method of Communication
Email: _____
Phone: _____

Home Health, DME, and Home Infusion Intake Sheet

Phone: 844-215-4264 **Fax: 844-215-4265**

Eligibility Effective Date:	❑ **Medicare**		**Date of Referral:**
Health Plan ID #:	❑ **Male**	❑ **Female**	
Patient Last Name:	**First Name:**		
Address:			
Phone #:	**DOB:**	**County:**	
Allergies:	**Ht/Wt:**	**Diabetic:** ❑ Yes ❑ No	
Emergency Contact:	**Phone #:**		
PCP:	**Phone #:**		
MD Ordering:	**Phone #:**		
Referral Person:	**Phone #:**		
❑ **Hospital** ❑ **SNF** ❑ **MD Office** ❑ **Case Mgmt.**			
Patient Diagnosis:	**Code:**		
Procedures Performed:			
Facility Name:	**Admit Date:**	**D/C Date:**	

❑ **HHC – Home Health Request** **SOC:** _____

❑ **INFUSION – Home Infusion Therapy Request**

INTRAVENOUS ACCESS:

Last Dose Administered:	**Due Date/Time: (next dose)**
Delivery Address:	**No. # Units:**

❑ **DME – DME Request: (For Oxygen – Please include the oxygen prescription form)**

_____ ____/____/____

(Physician Signature) (Date)

Requirements on Orders

For all DME, HH, and Infusion orders, the following information is required: Patient Demographics, Prescription or Physician's Orders, Diagnosis, Height, and Weight.

Trach Patient Requiring Oxygen	Non-Oxygen Trach Patients
Specific O2 Percentage (FIO2) – **no liter flow required**	**50 PSI Compressor to humidify the trach**
Cool humidity via trach collar	**Trach Collar** (Adult or Pediatric)
Usage (PRN or Continuous)	**Suction Machine – Stationary or Portable**
Method of Intake: Via Trach Collar	**Suction Catheters** (size is required) **and Yankauers**
Oximetry/Blood Gas Results	**Large Volume Nebulizer**
Suction Machine (size is required) **and Yankauers**	**Corrugated Tubing**
Large Volume Nebulizer	**Trach Care Kits**
Corrugated Tubing	**Trach Ties**
Trach Care Kits	**Trach Tube Brand/Size and Letters**
Trach Ties	**Prescription/Physician's Orders**
Trach Tube Brand/Size and Letters	**Diagnosis with Diagnosis Codes**
Prescription/Physician's Orders	**Length of Need**
Diagnosis with Diagnosis Codes	
Length of Need	

Home Health Orders	Home Health / I.V.
Home Health Care Orders	**Home Health Care/RN for IV Antibiotics**
Specific RN Eval and Disciplines (PT, OT, MSW, HHA, ST)	**Name of Medication**
Specific Wound Care Orders and Supplies*	**Dosage**
***Description, Modality, (detail wound care)**	**Frequency and Duration**
Enteral Feedings *(see requirements on Equipment Orders)*	**Diagnoses**
Diagnoses	**Route of Administration (I.V., I.M., Sub-Q, or Injection)**
Prescription / Physician's Orders	**Last Dose / Next Dose Due**
MD Signature Required (No APRN, PA)	**Type of Line / (Access Picc, Peripheral, Groshong Cath)**
	Allergies
	MD Signature Required (No APRN, PA)
	Prescription/Physician's Orders

Infusion Orders Antibiotics	TPN
Name of Medication	**Formula ingredients including Electrolytes**
Dosage	**Specify if Continuous or cycle**
Frequency and Duration	**Dosage**
Route of Administration (I.V., I.M., Sub-Q, or Injection)	**Frequency and Duration**
Last Dose / Next Dose Due	**Route of Administration**
Type of Line / (Access Picc, Peripheral, Groshong Cath)	
Allergies	**History & Physical**
Dosage	**Labs**
Prescription/Physician's Orders	**Medication Reconciliation form or MAR**
Confirm First Dose Given	**Allergies**
MD Signature Required (APRN, PA accepted with MD approval)	**Diagnosis**
	Prescription/Physician's Orders

Requirements on Equipment Orders

For all DME, HH, and Infusion orders, the following information is required: Patient Demographics, Prescription or Physician's Orders, Diagnosis, Height, and Weight.

Oxygen	Nebulizer Compressor	Suction Pump
Liter Flow	Diagnosis	Prescription/Physician's Orders
Frequency of Use (PRN or Continuous)	Length of Need	Frequency
Method of Intake	Prescription/Physician's Orders	Type of Catheter
Diagnosis	Medication	Catheter Size (8fr to 14fr)
Oxygen Saturation or PO2 Results		Length of Need
Prescription/Physician's Orders		
Physician Signature		
Physician Name Printed		
Physician NPI		

CPAP	Bipap	Vent
Settings	Settings	Tidal Volume or minute volume
Sleep Study	Sleep Study	Respiratory Rate
Prescription / Physician's Orders	Prescription / Physician's Orders	Oxygen Concentration (in % FIO2)
Mask Size (S, M, or Large)	Mask Size (S, M, or Large)	SIMV, if applicable (breaths per minute)
Headgear Size (S, M, or Large)	Headgear Size (S, M, or Large)	PEEP or CPAP, if applicable (in centimeters of water pressure)
Ramp Setting	Ramp Setting	Continuous or desired hours on ventilator
Length of Need	Length of Need	Vent setting must be verified by RT

Tens of Muscle Stimulator	Lymphedema Pump	Nutrition
2 leads or 4 leads	Type of pneumatic compressor	Nutrition type and strength
Setting (OHMS 1 to 8)	Segmental, Segmental W/O CAL	Method of Intake (pump, bolus, or gravity)
Daily hours of treatment	Pressure or segmental with CAL	Cc's per hour and hours per day
Area to perform treatment	Measurement of the area	
Length of need		

Continuous Passive Motion Machine (CPM)
The following information must be obtained by Customer Services Representative when processing a CPM order:
Flexion angle expressed in degrees
Extension angle expressed in degrees
Therapy Duration (i.e. Q2Hrs TID) = 2 hours, 3 times a day
Length of therapy (i.e., 14 days)

Requirements on Orders

For all DME, HH, and Infusion orders, the following information is required: Patient Demographics, Prescription or Physician's Orders, Diagnosis, Height, and Weight.

Portable Concentrator Order for Travel	Portable Concentrator Order for Daily Use
Complete POC Prescription Form	Complete POC Prescription Form
Referral Authorization HCPC E1392	Referral Authorization HCPC E1392
Letter of Medical Necessity	Letter of Medical Necessity
Traveling Date (Departure and Return)	Liters per Minute
Method of Travel (Airplane, Car, Cruise Ship, Train)	Oximetry/Blood Gas results if O2 Rx on File expired
Length of Travel Time	Clinical Note
Oximetry/Blood Gas results if O2 Rx on file expired	Diagnosis
Clinical Note	
Diagnosis	

PMD Orders	Repair to Patient's own PMD/Customer Orders
Prescription/Physician's Orders	Prescription/Physician's Orders
Referral Authorization	Diagnosis
*HCPC based on equipment being ordered	Clinical Notes
Diagnosis	Authorization HCPC K0739 with price quoted
Clinical Notes	PEEP or CPAP, if applicable (in centimeters of water pressure)
Face-to-Face Evaluation*	
Must be within 45 days	

Customer Wheelchair Orders
Prescription/Physician's Orders
Diagnosis and Clinical Notes
*Face-to-Face Evaluation (must be within 45 days)
Authorization with HCPC EW1220 with price quoted

Home Health Cheat Sheet Qualifying Criteria

1. In order to be generally appropriate for home care services, patients must continuously meet the following criteria:

    - The patient's clinical needs can be met at home.
    - The patient can either self-care or there is a paid or voluntary reliable primary caregiver to meet the needs of patients when staffing cannot be provided or between home visits.
    - The patient's home environment supports home care services.

2. Patient must be homebound. A Patient will be considered to be homebound if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence without a taxing effort and/or the aid of supportive devices such as canes, walkers, wheelchairs, etc.

3. Care must be intermittent.

4. Patient must require a skilled need i.e., skilled nurse, physical therapy or speech therapy.

5. Skilled nurse orders must require the skill of a nurse, i.e., injection, IV, wound care. Taking vital signs does not require the skill of a nurse, glucometer checks are not a skill, changing a colostomy bag is not a skill, placing cataract eye drops is not a skill.

6. Patient must have a physical therapy diagnosis to quality for physical therapy visits, i.e., new CVA, new fracture, ORIF, total knee/hip, functional decline, unstable gait, etc. "Weakness" is not a qualifying diagnosis.

7. A social services visit (MSW) is covered when patient has skilled services in the home (SN, PT, ST).

8. What is Not Covered by Medicare:

    - Help getting a bath and other types of personal care unless skilled services are also ordered.
    - 24 hour care at home
    - Meals delivered to your home
    - Homemaker/companion services
    - Venipuncture – lab draws (if only reason for home health)

Source: CMS HIM 11 – Medicare Manual

Guide for Home Health Care

This information sheet is designed as a guide to help determine the client's eligibility for covered home health care services.

First

Determine that the client meets the following criteria:

1. There is a physician's order for all care to be provided. The primary physician develops a plan of care and agrees to review the plan periodically.
2. The client requires intermittent or part-time care as described below.
3. The client is homebound, defined as a functional impairment that limits the ability to leave the residence without a taxing effort. Remember that being blind, deaf or paralyzed does not automatically constitute an acceptable homebound status. A client's diagnosis alone does not support homebound status, nor does an appliance, i.e., foley catheter. Also, remember that if a client is able to drive, even if it is a specially equipped automobile, he or she does not satisfy the homebound requirement. The client must require the assistance of another person to leave the home. A client is allowed to leave home for Physician's appointment and for occasional short trips to accomplish personal business. If a client leaves home on a frequent basis for training, day care, etc., he or she is not considered homebound.

In addition, the client must require one of the following services:

- Nursing care (must be part-time or on an intermittent schedule)
- Physical therapy
- Speech therapy

The following are some definitions to help you in determining eligibility for care.

Nursing

Definitions of Nursing care includes skilled assessment, direct care tasks, and teaching and training. The assessment, direct care and teaching and training activities must require the expertise of a trained nurse, in order to effectively benefit the client. Examples of skilled assessment include signs and symptoms related to a specific disease process, effectiveness of medication regimen, effectiveness of disease management, and wounds for healing process. Examples of direct care include, but are not limited to injections, intravenous therapy, wound treatment, bladder catheter maintenance, tube feeding, and respiratory treatments. Teaching and training include disease process, therapeutic diet, medication regimen, and disease management.

Physical Therapy

Physical therapy services include Gait training, transfer training, passive and active range of motion training, muscle re-education, and establishment of an effective home exercise program. In order to qualify for physical therapy services, the client must exhibit a current condition or medical diagnosis that supports the benefit of the therapy. Examples would include recuperation from a fracture, postoperative recuperation from an orthopedic procedure, or marked functional decline related to an extended illness. Remember that the functionally status of the client must support the need for the therapy services. Physical therapy evaluations are not covered for palliative purposes.

Speech Therapy

Speech therapy services include treatment of swallowing disorders, communication disorders, both cognitive and functional. Interventions would include assessment, speech, voice and language communication tasks, with cueing, and restorative exercise for swallowing, and chewing. Examples would include a post (CVA) stroke patient who has lost the ability to speak, a patient who has lost the use of the swallowing function and cannot maintain adequate nutrition. In order for a client to qualify for speech therapy, the evaluation must indicate that the therapy will be beneficial on improving the disorder.

Once the client qualifies for home health services, additional services will be covered when provided in conjunction with the qualifying services (SN, PT, and ST)

These services include occupational therapy. Home health aide services (intermittent or part time only), Medical Social Services, and medical supplies or equipment provided by the agency in the provisions of care.

Intermittent care is defined as care that can be accomplished with visits and is not continuous in nature. (A visit is accomplished in less than two hours).

Occupational Therapy

Occupational therapy services include assessment, teaching and supervising task-oriented activities to restore functional abilities and instruction of devices to assist in regaining or improving motor function and ability to perform activities of daily living. In order to qualify for occupational therapy services, the client must exhibit a current condition or medical diagnosis that supports the benefit of the therapy.

Medical Social Services

Medical Social Services may be provided to the client or the family member for resolution of social or emotional problems that are expected to be an impediment to the effectiveness of the medical treatment (i.e., skilled nursing, physical therapy, and speech therapy) and or rate of recovery.

The medical social visit may not be for the purpose of completing forms or filing paperwork related to government assistance programs.

Home Health Aide

Home Health Aide services may include personal care, i.e., bathing, hair care, oral care, grooming, and light housekeeping in the patient's area, preparing and serving meals. The aide services do not include cooking or providing housekeeping chores for the other members of the household. This service is covered only when the patient is receiving skilled care (i.e., skilled nurse, physical therapy or speech therapy).

Delivery of Services

Home health services are not designed to provide emergency care. We have up to 24/48 hours to staff a case from the time that we received a referral. However, on certain IV cases we will staff the case with 6 hours.

Examples of Home Health Complete Orders

- **Home Health:**
  1. Home Health Care (HHC) RN Eval, PT Eval, PT and HHA
  2. Home Health Care RN Eval for teaching of new onset of CHF, for signs, symptoms and new medications
  3. Home Health nurse for diabetic teaching of new medication Glucotrol 5mg po daily and glucometer
  4. Home Health Care for insertion of a Foley catheter 16fr 30cc balloon/change Q month and PRN. Instruct patient and caregiver on Foley Care.

  Note: RNE can be ordered when there is a skilled service identified such as a new DX that requires a nurse to teach disease process/skilled monitoring, teaching of a new medication, foley catheter insertion/care, peg tube feeding care/teaching, and trach care teaching. PT/OT/ST requires an acute DX (CVA, Hip FX, etc.) and frequency is determined on evaluation.

- **Home Health Orders involving Wound Care:**
  1. HHC RN Eval, wound care on left leg: cleanse with H2O and apply Silvadene cream QD
  2. HHC, second degree burn right forearm; nurse to cleanse wound with soap and water, pat dry and apply Silvadene cream, cover with Telfa dressing and secure with tape QD
  3. HHC, nurse to cleanse wound on sacrum with normal saline and apply Duoderm, change Q 3 days

  Note: Type of wound, location, cleansing instructions, application of medications or specific wound care product, and how often to change are required.

- **Home Health Orders involving IV/Infusion (follow first dose policy):**
  1. HHC nurse to administer Lovenox 30 mg SQ q 12 hrs. x 21 days (last & next dose needed)
  2. HHC nurse to administer Vancomycin 1 gm IV q 12 hrs. x 10 days (last & next dose needed)
  3. HHC nurse to administer Glytrol 480cc q 6 hrs. w/150cc H2O flush
  4. HHC nurse to administer and teach how to self-administer Humulin 70/30 10 units Q AM

  Note: Name of medication, dose, frequency, duration, route of administration, type of line/access, height, weight, and allergies are required.

- **Home Health Orders involving Enteral/Formula Peg Tube Feeding Patients:**
  1. Home Health Care for instructions of peg tube feeding care. Ensure 65cc/hr via feeding pump continuous.
  2. Home Health Care for instructions of peg tube feeding care. Fibersource HN 1 can via bolus 5 times a day
  3. Home Health Care for instructions of peg tube feeding care. Ensure 40cc bolus Q6 hours and flush with 100cc of H2O.

OXYGEN PRESCRIPTION

Physician Name _____ **NPI #** _____

The Department of Business and Professional Regulation (DBPR) and Medicare / Medicaid requires complete physician orders for medical oxygen to include the liter flow, hours of use, application device, and as appropriate, orders for the portable cylinders and oxygen conserving device. Medical oxygen is classified as a drug, as such; prescriptions are valid for only one year. Prescriptions must be renewed on an annual basis for the therapy to be continued. As the prescribing physician of record, please complete the following form in its entirety, sign and return fax as soon as possible. Please do not hesitate to call with any questions.

Patient Name: _____ Date of Order: _____

Date of Face-to-Face visit with Physician regarding Home Oxygen Therapy: _____

Diagnosis: _____

Length of Need: _____ ***(99 = Lifetime)***

[ ] New Prescription **[ ] Prescription Renewal** **[ ] Update Current Prescription**

[ ] Discontinue Oxygen and Pick-Up Equipment

Oxygen Saturation or PO_2 results: _____ **Date of Test:** _____

Liter Flow per Minute: _____

Via: [ ] Nasal Cannula [ ] Simple Mask [ ] Other _____

Frequency of Use: [ ] Continuous [ ] With Exertion [ ] Hours of Sleep

[ ] Bleed into CPAP / BiPAP [ ] PRN [ ] Other: _____

Delivery Device: [ ] Concentrator [ ] Portable Cylinders

[ ] Liquid Helios Portable [ ] Liquid Stationary (reservoir)

[ ] Portable Oxygen with Conserving Device

Comments: _____

Physician's Signature: _____ **Date:** _____

(Stamped signature and date are not accepted) ***(Not valid without date)***

Physician Printed Name: _____

Integrated Home Care Services
3700 Commerce Parkway Miramar, FL 33025 | 844-215-4264

OXYGEN PRESCRIPTION FOR POC

Physician Name _____ **NPI #** _____

The Department of Business and Professional Regulation (DBPR) and Medicare / Medicaid requires complete physician orders for medical oxygen to include the liter flow, hours of use, application device, and as appropriate, orders for the portable cylinders and oxygen conserving device. Medical oxygen is classified as a drug, as such; prescriptions are valid for only one year. Prescriptions must be renewed on an annual basis for the therapy to be continued. As the prescribing physician of record, please complete the following form in its entirety, sign and return fax as soon as possible. Please do not hesitate to call with any questions.

Patient Name: _____ **Date of Order:** _____

Date of Face-to-Face visit with Physician regarding Home Oxygen Therapy: _____

Diagnosis: _____

Length of Need: _____ ***(99 = Lifetime)***

[ ] New Prescription [ ] Prescription Renewal [ ] Update Current Prescription

[ ] Discontinue Oxygen and Pick-Up Equipment

Oxygen Saturation or PO_2 results on Room Air: _____ **Date of Test:** _____

Liter Flow per Minute: _____

Via: [ ] Nasal Cannula [ ] Simple Mask [ ] Other _____

Frequency of Use: [ ] Continuous [ ] Pulse Dose

Delivery Device: [ ] Portable Oxygen Concentrator

For a Portable Oxygen Concentrator a letter of medical necessity is required.

Comments: _____

Physician's Signature: _____ **Date:** _____

(Stamped signature and date are not accepted) ***(Not valid without date)***

Physician Printed Name: _____

CPAP / BiPAP PRESCRIPTION REQUEST

Dr. _____ **NPI:** _____

Patient Name: _____ **Date of Birth:** _____

Health Plan: _____

Diagnosis: _____ **Date Last Seen in Office:** _____

COPY OF THE SLEEP STUDY NEEDS TO BE INCLUDED:

_____

[ ] New Prescription **[ ] Update Current Prescription**

EQUIPMENT:

[ ] CPAP @ _____**cmH2O** **Ramp:** _____**Minutes**

[ ] BiPAP ST - IPAP: _____ **EPAP:** _____**Back-Up Rate:** _____

[ ] BiPAP AUTO (please note: no backup rate on this equipment)

Max IPAP Pressure _____ **Minimum EPAP Pressure** _____

Pressure Support _____

[ ] Other: _____

[ ] Heated Humidification **[ ] Chin Strap** **[ ] Heated Tubing**

PATIENT INTERFACE (Mask)

[ ] Full Face **[ ] Nasal** **[ ] Nasal Pillows** **Mask Size:** _____

Other: _____ **[ ] Oxygen Bleed-In @** _____**LPM**

Physician's Signature: _____ **Date:** _____
(Stamped signature and stamped date are not accepted) *(Not valid without date)*

PLEASE FAX ATTN: RESPIRATORY DEPARTMENT
Fax # 844-215-4265

INTEGRATED HOME CARE SERVICES

WOUND CARE ORDER FORM

For Care Plus send to ACS PHONE # 954-748-1966 FAX # 954-748-3748
For AvMed, Doctors, Devoted, Simply and MCCI Send to IHCS PHONE # 1-844-215-4264 FAX # 1-844-215-4265

Patient Name: _____ **DOB:** _____
Address: _____ **Phone #** _____
City: _____ **State**_____ **ZIPCODE**_____
Health Plan: _____ **Member ID #** _____ **Auth#**_____
IF PATIENT UNDER HHA AGENCY NAME: _____ **PHONE #** _____

PRIMARY DIAGNOSIS ON FILE / WOUND LOCATION
ICD-10 CODE_____ **Code Description**_____

REFILLS: ☐ 3 ☐ 6 **Ordering for** ☐ 30 Days or ☐ 14 days **START DATE:** ___/___/____

Use "✓" to indicate primary and secondary dressings for each wound. One dressing per change unless supportive documentation is attached. Doctor's orders are required with all forms.

PRIMARY DRESSING	QTY	WD1	WD2	WD3
	Ea/BX	X	X	X
Collagen ____2x2 _____ 4x4				
Collagen with Silver ____2x2 _____ 4x4				
Calcium Alginate ____2x2 ____4x4 ___Rope				
Silver Alginate ____2x2 ____4x4 ___Rope				
Hydrogel ____tube _____4x4 pad				
Silvery Hydrogel ____1.5oz tube ____3 oz tube				
Hydrocolloids Thick/Thin ____2x2_____ 4x4				
Hydrocolloids Bordered ____2x2_____4x4				
Gauze ____2x2_____4x4				
Gauze N/S ____2x2_____4x4				
( ) Xeroform ( ) Vaseline Gauze ( ) Adaptic				
Normal Saline 100ml				

SECONDARY DRESSING	QTY	WD1	WD2	WD3
	Ea/BX	X	X	X
ABD ____5x9 _____ 8x10				
Non Adherent Pad/Telfa 3x4 ( ) OTHER:				
Foam ____2x2 _____ 4x4				
Bordered Foam ____4x4 _____6x6				
Composite ____4x4 _____6x6				
Kerlix/Bandage Roll 4"				
Sofform/kling/conform __2" __3" __4"				
( ) Coban ( ) Elastic Bandage				
Cloth Tape __1" __2" __3"				
Mefix Tape __2" __4"				
Paper Tape __1" __2" __3"				
Other				

ADDITIONAL MEDICAL INFORMATION (REQUIRED) PLEASE ATTACH DR ORDERS FOR WOUND SUPPLY

WOUND 1	WOUND 2	WOUND 3
LOCATION:	LOCATION:	LOCATION:
LENGTH: _____CM	LENGTH: _____CM	LENGTH: _____CM
WIDTH: _____CM	WIDTH: _____CM	WIDTH: _____CM
DEPTH: _____CM	DEPTH: _____CM	DEPTH: _____CM
FREQUENCY CHANGE OF DRESSING:	( ) Q ( ) Q.O.D. ( ) Q.W.K	( ) OR: _____

IF THERE ARE ADDITIONAL WOUNDS, PLEASE ATTACH INFORMATION ON A SEPARATE SHEET

DOCTOR NAME: _____ **NPI:** _____ **PHONE:** _____

DOCTOR SIGNATURE: _____ **DATE:** _____

FUNCTIONAL MOBILITY EVALUATION

INTEGRATED HOME CARE SERVICES

THIS EVALUATION WILL GUIDE YOU THROUGH A STEP WISE PROCESS FOR PRESCRIBING MOBILITY PRODUCTS

PATIENT INFORMATION

Patient Name:		**SSN:**		
Address:		**Phone:**		
City:	**Zip:**	**DOB:**	**Ht:**	**Wt:**

MEDICAL EVALUATION

Date of Face-to-Face Evaluation: **Length of Need:**
ICD-10 Diagnoses:
Mobility devices currently used in the home: ( ) Cane ( ) Walker ( ) Manual WC ( ) Other:
Why are these no longer appropriate or safe?
1. Does the patient have mobility limitation(s) that significantly impair(s) his/her ability to perform one or more mobility related activity of daily living (MRADL)? ( ) Yes (Explain) ( ) No **( ) Safety ( ) Imbalance ( ) Weakness ( ) Dyspnea ( ) Pain ( ) Loss of ROM ( ) Hx of Falls** **Other:**
2. Are there other conditions that limit the patient's ability to participate in MRADLs in the home? **( ) Yes (Explain) ( ) No** **( ) Vision ( ) Cognition ( ) Hearing**
3. Can the limitations be compensated sufficiently that the provision of mobility assistive equipment (MAE) will reasonably be expected to significantly improve the patient's ability to perform or obtain assistance to participate in MRADLs in the home? ( ) Yes ( ) No (Explain)
4. Does the patient or caregiver demonstrate the capability & willingness to operate the power mobility device in their home? ( ) Yes ( ) No
5. Can the functional mobility deficit be sufficiently resolved with the use of a cane or walker? ( ) Yes ( ) No
6. Does the patient's home support the use of wheelchairs including a power mobility device to be used in the home for completion of MRADLs? ( ) Yes ( ) No
7. Does the patient have sufficient upper extremity function to self-propel a manual wheelchair in the home to complete MRADLs? (Consider and document limitations of strength, endurance, range of motion, coordination, presence of pain, or deformity) ( ) Yes ( ) No **Explain:**
8. Can the patient safely use a manual wheelchair? ( ) Yes ( ) No
9. Is there a caregiver who is available, willing, and able to provide assistance? ( ) Yes ( ) No
10. Does the patient have sufficient trunk strength, postural stability, hand grip, motor coordination, balance to sit upright, ability to stand and pivot, transfer and space in the home to safely maneuver a power mobility device? ( ) Yes ( ) No
11. Does the patient need and have the judgement, mental and physical capabilities to safely use a power mobility device in the home and MRADLs? ( ) Yes ( ) No
Physician's Name: **NPI:**
Physician's Signature: **Date:**

Return completed form to Integrated Home Care Services at 844-215-4265
ALL QUESTIONS MUST BE COMPLETED

CUSTOM WHEELCHAIR PT EVALUATION

Full Mobility Assessment:

1. **Transfers (Bed Mobility/Toileting/etc.)**
2. **How does the patient transfer?**
3. **Activities of Daily Living (ADL) and Mobility Related Activities of Daily Living (MRADL)**
4. **Ambulation Assistance**
5. **Basic Measurement**
6. **Range of Motion**
7. **Outlining Limiting Factors**
8. **Full Body Assessment (Documenting any ulcers)**
9. **Functional Assessment**
10. **Recommendation of a PMD or Manual Device to meet the needs of the patient**