PHYSICIAN'S FACE TO FACE ASSESSMENT FOR PROSTHETIC DEVICE

PATIENT LAST NAME:	FIRST NAME:	DOB:	PATIENT EVALUATION DATE:
AMPUTATION TYPE:	AMPUTATED SIDE:	AMPUTATION DATE:	
ICD-10:	TYPE OF PROSTHETIC DEVICE REQUESTED:	HEIGHT:	WEIGHT:

1. MEDICAL NECESSITY AND ABILITY TO FUNCTION WITH A PROSTHESIS:

History of the present condition(s), past medical history, and prior use of prosthesis (if any) that is relevant to patient's functional deficits:

Description of any assistive devices patient **currently** uses for mobility:

Description of patient's current ability and potential ability to ambulate and function with a prosthesis:

Patient is expected to be able to maintain ambulation within ______ months.

Description of any assistive devices patient might require for ambulation, once fit with a new prosthesis:

Description of how patient communicated or demonstrated his/her desire to function with a prosthesis:

2. FUNCTIONAL LEVEL:

Current Functional Level: ☐K0 ☐K1 ☐K2 ☐K3 ☐K4 | Expected Functional Level: ☐K0 ☐K1 ☐K2 ☐K3 ☐K4

Explanation for expected difference in functional level if the Current and Expected Levels are not the same:

Description of Activities of Daily Living that patient is expected to perform at Expected Functional Level:

3. CARDIOPULMONARY EXAMINATION:

Description of patient's cardiopulmonary status:

4. MUSCULOSKELETAL EXAMINATION:

LEFT	RANGE OF MOTION	MANUAL MUSCLE TEST	RIGHT	RANGE OF MOTION	MANUAL MUSCLE TEST
Shoulder			**Shoulder**		
Elbow			**Elbow**		
Wrist			**Wrist**		
Hand			**Hand**		
Hip			**Hip**		
Knee			**Knee**		
Ankle			**Ankle**		

5. NEUROLOGIC EXAMINATION:

Gait Assessment:		**Other:**
Balance and Coordination:		

6. REPAIR OR REPLACEMENT OF PROSTHETIC DEVICE/SPECIAL INSTRUCTIONS:

Description of current prosthesis and need for repair or replacement OR special request:

Current Functional Level: ☐K0 ☐K1 ☐K2 ☐K3 ☐K4 Expected Functional Level: ☐K0 ☐K1 ☐K2 ☐K3 ☐K4

SIGNATURE:____ **DATE:**______________________

PHYSICIAN NAME (PRINT):____________________________________ **NPI:**______________________