Physician's Order – Cane/Quad Cane / Crutch / Walker

Patient Information
Name:
Address:
City, State, Zip:
Medicare #:
DOB:

Provider Information
Name: **Arvada Pharmacy, Inc.**
Address: **10382 Ralston Rd**
City, State, Zip: **Arvada, CO 80004**
Phone: **720-707-2444**
Fax: **720-707-2400**
NPI: **1376000950**

Length of need: [____] months [____] Lifetime

Item Ordered (Please include detailed description):

Diagnosis ICD-10 Code: _____
(ICD-10 code must be to the highest level of specificity)

Instructions: Please answer the following questions.
If you have any changes, please cross out, write in correction, initial the change, and sign and date the order.

Yes No Does the patient have a mobility limitations that significantly impacts his/her activity to participate in one or more Mobility-Related Activities of Daily Living Skills (MRADLS) in the home, such as toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home?

A mobility limitation is one that:

Yes No Prevents the beneficiary from accomplishing the MRADL entirely, or,

Yes No Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADLS; or,

Yes No Prevents the beneficiary from completing the MRADLS within a reasonable time frame;

Yes No The beneficiary is able to safely use the cane or crutch; and,

Yes No The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.

If all of the criteria above are not met, the cane or crutch will be denied as not reasonable and necessary.

MAE (Mobility Assistive Equipment)

Yes No Are there other types of limitations present?

Yes No Cognitive Yes No Visual Yes No Positioning

Yes No Spasticity Yes No Environmental

Yes No Can the limitations be compensated with other types of devices/situations?

Yes No Glasses Yes No Caregivers Yes No Assistance

Yes No Can the patient safely use /operate the mobility device prescribed?

Yes No Can the patient use a cane for ambulation to complete MRADLsdue to condition causing impaired ambulation, and is he/she able to use the cane safely?

Yes No Does he/she require a walker for increased stability and security not provided by a cane?

Yes No Can the item ordered be used in his/her usual environment for all MRADLS?

I, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment for this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and is available upon request.

_____ _____
Physician's Signature **Date**

Physician Name: **NPI:**
Address: **Phone:**
Fax: