



Patient Information

Name: _____ Home Address: _____ City, State, Zip: _____ Home Phone: _____ Other Phone: _____ e-mail: _____	Height: _____ Weight: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth: _____ Age: _____
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Health Related Information *If yes, where?*

Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Heart Condition	<input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
High Blood Pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	Back Pain	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Medication(s)	<input type="checkbox"/> No <input type="checkbox"/> Yes		

Identify any related or relevant physical conditions or injuries: _____

Has your weight remained consistent for the past year? Yes No: _____ # Gained Lost

Daily Living Information

Living Status: Live Alone Live with Assistance

Living Conditions:

<input type="checkbox"/> Level Surfaces	<input type="checkbox"/> Level Surfaces with Stairs
<input type="checkbox"/> Uneven Surfaces	<input type="checkbox"/> Uneven Surfaces with Stairs

Normal Daily Activity: Seated _____% Standing/Walking _____%

Activities of Daily Living:

<input type="checkbox"/> Bicycling	<input type="checkbox"/> Gardening
<input type="checkbox"/> Long Walks	<input type="checkbox"/> Hiking
<input type="checkbox"/> Shopping	<input type="checkbox"/> Domestic Chores (<i>Laundry, house cleaning etc.</i>)
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Employment Status	<input type="checkbox"/> Employed as: _____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Student
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Prosthesis Assessment						
Patient Name: _____						
	Poor	Fair	Good	Very Good	Excellent	Comments
Comfort in the top of the socket	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Comfort in the distal end of the socket	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Suspension	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Ease of getting the socket on	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Ease of getting the socket off	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Overall comfort of the socket	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Ability of the knee to keep up with my walking speed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Ease of standing up out of a chair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Ease of sitting down into a chair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My overall balance with the prosthesis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My confidence walking in large crowds	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My confidence walking in unfamiliar places	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My overall confidence using the prosthesis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My ability to walk at a slow speed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My ability to walk at a fast pace	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My ability to jog/run	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My ability to change speeds while walking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My stability on uneven surfaces (<i>rocks, gravel, etc.</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My ability to walk down stairs step over step	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My ability to walk down ramps with confidence	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Weight of my prosthesis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Cosmetic look of the prosthesis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Cosmetic look of the knee in a seated position	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Prosthetic shape resembles my sound side	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Fit of the prosthetic foot in the shoe	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	

Patient's Initials _____ Date _____



Activity & Comfort Assessment						
Patient Name: _____						
	Always	Often	Sometime	Seldom	Never	Comments
My socket is hot and makes me sweat	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I get a rash with my socket	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My residual limb volume fluctuates	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I have pressure points in my socket	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I have muscle fatigue/cramps in my residual limb	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I experience phantom pain in my residual limb	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I require cane/crutches to get around	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I get tired at the end of the day	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I have low back pain or discomfort	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I have pain/discomfort in my hips	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
While standing, I am afraid the knee might buckle	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I stub my prosthetic toe on the ground when walking	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My prosthesis holds me back from doing normal day-to-day activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My prosthesis holds me back from doing special activities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My knee buckles while I am standing	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I am unable to wear some clothing items because of the prosthesis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I wear short pants or skirt with my prosthesis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My prosthesis feels heavy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
My knee does not keep up with me when I walk fast	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I fall while wearing my prosthesis	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I avoid going up or down stairs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I avoid going up or down ramps	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I have to stop for a rest when out in public	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
I use disabled/handicap parking spaces	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
Walking in crowds makes me feel unstable	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	

Patient's Initials _____ Date _____

Patient Name: _____



Amputation Details	
<p style="text-align: center;">Left Side Amputation <input type="checkbox"/> None</p> <p><input type="checkbox"/> AK <input type="checkbox"/> Hip/Hemi <input type="checkbox"/> KD</p> <p><input type="checkbox"/> BK <input type="checkbox"/> Partial Foot <input type="checkbox"/> Upper Limb</p> <p>Limb Length <input type="checkbox"/> Short <input type="checkbox"/> Mid-thigh <input type="checkbox"/> Long</p> <p>Cause of Amputation: _____</p> <p>Date of Amputation: _____</p> <p>Age of Prosthesis: _____</p>	<p style="text-align: center;">Right Side Amputation <input type="checkbox"/> None</p> <p><input type="checkbox"/> AK <input type="checkbox"/> Hip/Hemi <input type="checkbox"/> KD</p> <p><input type="checkbox"/> BK <input type="checkbox"/> Partial Foot <input type="checkbox"/> Upper Limb</p> <p>Limb Length <input type="checkbox"/> Short <input type="checkbox"/> Mid-thigh <input type="checkbox"/> Long</p> <p>Cause of Amputation: _____</p> <p>Date of Amputation: _____</p> <p>Age of Prosthesis: _____</p>

<p style="text-align: center;">Assistive Devices Currently Being Used</p> <p style="text-align: center;"> <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> None </p>

Functional Level	<input type="checkbox"/> K0 <small>No ability or potential to ambulate or transfer.</small>	<input type="checkbox"/> K1 <small>Ability or potential to transfer or ambulate on level surfaces at fixed cadence.</small>	<input type="checkbox"/> K2 <small>Ability or potential to traverse low level environmental barriers.</small>	<input type="checkbox"/> K3 <small>Ability or potential to ambulate with variable cadence.</small>	<input type="checkbox"/> K4 <small>Ability or potential to ambulate which exceeds basic ambulating skills.</small>
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Present Prosthesis	<input type="checkbox"/> Definitive <input type="checkbox"/> Preparatory <input type="checkbox"/> IPOP	<input type="checkbox"/> None, New Amputee* <small>skip the remainder of this page proceed to residual limb evaluation on page 5</small>
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Gait Evaluation	Length of Prosthesis <input type="checkbox"/> Short <input type="checkbox"/> Long <input type="checkbox"/> Correct <small>Details: _____</small>
	ML Stability <input type="checkbox"/> Lateral Shift <input type="checkbox"/> Medial Shift <input type="checkbox"/> Correct <small>Details: _____</small>
	Step Length <input type="checkbox"/> Short Pros. Step <input type="checkbox"/> Long Pros. Step <input type="checkbox"/> Correct <small>Details: _____</small>

Gait Deviations	Abducted Gait <input type="checkbox"/> Yes <input type="checkbox"/> No _____
	Circumducted Gait <input type="checkbox"/> Yes <input type="checkbox"/> No _____
	Vaulting <input type="checkbox"/> Yes <input type="checkbox"/> No _____
	Knee Instability <input type="checkbox"/> Yes <input type="checkbox"/> No _____

Falls	In the past year, have you fallen while wearing your prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes
	IF YES: How many times have you fallen? _____ Times
	Were you injured when you fell? <input type="checkbox"/> No <input type="checkbox"/> Yes
	IF YES, describe your injuries: _____

Other Injuries, Observations & Comments:

Evaluation of Current Prosthetic Components	<i>For New Amputee; proceed to residual limb evaluation on this page</i>
Patient Name: _____	



Please clarify below why the present components do not enable the patient to achieve activities of daily living (ADLs).

FOOT: _____ *Acceptable as is, will reuse*
 Needs to be replaced because: _____

SUSPENSION: _____ *Acceptable as is, will reuse*
 Needs to be replaced because: _____

SOCKET: _____ *Acceptable as is, will reuse*
 Needs to be replaced because: _____

LINER/ INSERT: _____ *Acceptable as is, will reuse*
 Needs to be replaced because: _____

For Above Knee Prosthesis Only

KNEE* : _____ *Acceptable as is, will reuse*
 Needs to be replaced because: _____

** If current knee is an MPK and requires replacement, manufacturer's repair estimate is requested.*

Residual Limb Evaluation

Skin Condition <i>Details</i>	<input type="checkbox"/> Normal	<input type="checkbox"/> Discoloration	<input type="checkbox"/> Open Wounds
Limb Shape <i>Details</i>	<input type="checkbox"/> Normal	<input type="checkbox"/> Bulbous	<input type="checkbox"/> Conical
Contracture <i>Details</i>	<input type="checkbox"/> Flexion	<input type="checkbox"/> Abduction	<input type="checkbox"/> None Present
Other <i>Details</i>	<input type="checkbox"/> Scars	<input type="checkbox"/> Bony Prominence	<input type="checkbox"/> Neuroma

Residual Limb Observations & Supplementary Clinical Indications



Prosthetic Recommendation

Entire New Prosthesis

Patient Name: _____ requires:

Replacement Components Only

Change Required due to:
Check all that apply

<input type="checkbox"/> Prosthetic Knee Instability (AK only)	<input type="checkbox"/> New Prosthetic Wearer	<input type="checkbox"/> Change in Residual Limb
<input type="checkbox"/> Irreparable Damage	<input type="checkbox"/> Functional Level Change	<input type="checkbox"/> Normal Wear & Tear
	<input type="checkbox"/> Weight Gain # of lbs. _____	<input type="checkbox"/> Weight Loss # of lbs. _____

Recommended Componentry

Clinical Rationale

Foot: _____ <i>Comments:</i>	<input type="checkbox"/> Reduce Energy Consumption <input type="checkbox"/> Walk on Uneven Terrain	<input type="checkbox"/> Increased Stability <input type="checkbox"/> Variable Cadence
Knee: (AK Only) _____ <i>Comments:</i>	<input type="checkbox"/> Reduce Energy Consumption <input type="checkbox"/> Variable Cadence	<input type="checkbox"/> Increased Stability <input type="checkbox"/> Increased Comfort
Suspension: _____ <i>Comments:</i>	<input type="checkbox"/> Reduce Skin Abrasion <input type="checkbox"/> Increased Prosthetic Control	<input type="checkbox"/> Increased Stability <input type="checkbox"/> Increased Comfort
Socket: _____ <i>Comments:</i>	<input type="checkbox"/> Increased Control <input type="checkbox"/> Increase Muscle Movement	<input type="checkbox"/> Increased Stability <input type="checkbox"/> Increased Comfort
Liner/Insert: _____ <i>Comments:</i>	<input type="checkbox"/> Control Volume Change <input type="checkbox"/> Reduce Stress on Skin	<input type="checkbox"/> Increased Comfort <input type="checkbox"/> Improve Suspension
Protective Cover: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Protect Internal Components	<input type="checkbox"/> Moisture Protection
Total Contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Comments:</i>	<input type="checkbox"/> Increased Venous Return <input type="checkbox"/> Increased Comfort	<input type="checkbox"/> Increased Weight Bearing Surface
Ultra-Lite Materials: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Reduced Weight	<input type="checkbox"/> Increased Durability

General Observations & Comments:



Patient Name: _____

Activities of Daily Living Evaluation					
To accomplish Activities of Daily Living the patient requires the ability to:	Never	Rarely	3-4 times a Month	3-4 times a Week	Daily
1. Walk with variable cadence*	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Walk a distance greater than 400 yards*	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Walk on uneven terrain (gravel, grass, curbs)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Walk up and down stairs	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Walk up and down ramps	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Carry or lifting items	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Walk in public areas or crowds*	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Get in and out of a car	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. Bending, kneeling or stooping	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Walk, stand or work in confined areas	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Functional Capabilities					
Patient can:	Not Possible	Potential	Exhibits ability to accomplish	Can accomplish	Presently does daily basis
11. Transfer without assistive devices	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. Ambulate on level surfaces at fixed cadence	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. Traverse low level environmental barriers	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
14. Ambulate with variable cadence*	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
15. Ambulate at a faster than baseline rate*	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Prosthetic Reliance Evaluation					
Patient Limb/ Joint Strength:	Normal	Good	Fair	Poor	Trace
16. Right side hip extension	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. Left side hip extension	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. Right side knee extension (AK on Right side...score 4)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. Left side knee extension (AK on Left side...score 4)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. Sound side ankle plantar/dorsi flexion (Bilateral AK or AK/BK patient...score 4)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Special Consideration Evaluation					Score
21. Hip replacement (either side)					<input type="checkbox"/> 1
22. Unilateral upper extremity amputation					<input type="checkbox"/> 1
23. Neuropathy on sound side					<input type="checkbox"/> 1
24. Asthma					<input type="checkbox"/> 1
25. Short transfemoral amputation (less than 5" femoral length)					<input type="checkbox"/> 1
26. Low back or hip pain					<input type="checkbox"/> 1
27. Bilateral transtibial amputation or transfemoral/transtibial					<input type="checkbox"/> 2
28. Bilateral trans femoral					<input type="checkbox"/> 2
29. Comorbidity involving orthotic intervention on sound side lower limb					<input type="checkbox"/> 2
30. Hip disarticulation or hemipelvecotmy					<input type="checkbox"/> 2
31. Legally impaired vision					<input type="checkbox"/> 2
32. Heart disease					<input type="checkbox"/> 2
33. Short transtibial amputation (less than 5" tibial length)					<input type="checkbox"/> 3
34. Bilateral upper extremity amputation					<input type="checkbox"/> 3

ADL Score	Functional Score	Reliance Score	Special Score	Total

Cadence Score *	(Total of questions # 1, # 2, # 7, # 14 & # 15)
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Patient Name: _____



Medical Necessity Verification

Medically necessary care is justified and validated based upon the patient meeting the five criteria listed below.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Medically Necessary care and treatment is recommended or approved by a Physician</p> <p><i>A prescription and/or letter of medical necessity have been obtained by the patient's referring physician requesting the patient be provided with requested services.</i></p>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Is consistent with the patient's condition or accepted standards of good medical practice</p> <p><i>The prescribed services are established as accepted and routinely prescribed prosthetic option for functional level 3 individuals; it is recognized and approved for care by Medicare and the Veterans Administration.</i></p>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Is medically proven to be effective treatment of the condition</p> <p><i>Both Medicare & the Veterans Administration approve the prescribed services for functional level three (FL3) individual as an effective prosthetic treatment. Combined with FDA approval and the VA fitting guidelines and criteria, the prescribed services have been identified and accepted by physicians, insurance companies, governmental agencies and the rehabilitation community nationally and internationally as a routine and a standard means of prosthetic treatment nationwide.</i></p>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Is not performed mainly for the convenience of the patient or provider of medical services</p> <p><i>The prescribed services are deemed as medically necessary and could potentially be considered to be inconvenient for both the patient and the provider. For the patient, the device must be plugged in each night so the batteries can re-charge. For the practitioner, this technology involves advanced training to program for the patient's use.</i></p>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Is not conducted for research purposes.</p> <p><i>By answering "Yes" this confirms that the above listed individual is not involved with any research programs regarding his or her prosthesis.</i></p>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<p>Is the most appropriate level of service which can be safely provided to the patient</p> <p><i>Patient is a functional level three (FL3) individual capable of variable cadence and ambulation on uneven terrain. Patient meets Hanger and Medicare guidelines and this technology is considered medically necessary for the patient.</i></p>

Clinician Name Printed

Clinician Signature

Date