

## Face-to-Face Mobility Examination Report For a Power Wheelchair

<b>Patient Information</b>				<b>Date of Face to Face Examination:</b> _____			
Name: _____						HICM: _____	
Mailing Address: _____						Telephone: ( ) _____	
City: _____	State: _____	Zip: _____	DOB: _____	Age: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>		
<b>Physician or Treating Practitioner Information</b>							
Name: _____						UPIN: _____	
Mailing Address: _____						Telephone: ( ) _____	
City: _____				State: _____		Zip: _____	
<b>Current Symptoms, Related Diagnosis, and History (Must Be Completed by Treating Practitioner)</b>							
What medical conditions/diseases limit your patient's mobility in their home? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Central Vascular Disease / CVA  <input type="checkbox"/> COPD  <input type="checkbox"/> CHF  <input type="checkbox"/> Degenerative Joint Disease  <input type="checkbox"/> Diabetes/Neuropathy  <input type="checkbox"/> Other, Please describe: _____         </div> <div style="width: 33%;"> <input type="checkbox"/> Hemiplegia/Hemiparesis  <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> Muscular Dystrophy  <input type="checkbox"/> Osteoarthritis         </div> <div style="width: 33%;"> <input type="checkbox"/> Paraplegia/paresis  <input type="checkbox"/> Parkinson's Disease  <input type="checkbox"/> Renal Failure  <input type="checkbox"/> Rheumatoid Arthritis         </div> </div>							
How do the above conditions interfere with their ability to perform Activities of Daily Living (ADLs) in their home? <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Abnormality of Gait  <input type="checkbox"/> De-conditioning  <input type="checkbox"/> Edema  <input type="checkbox"/> Other, Please describe: _____         </div> <div style="width: 33%;"> <input type="checkbox"/> Fatigue  <input type="checkbox"/> Floundering  <input type="checkbox"/> Pain         </div> <div style="width: 33%;"> <input type="checkbox"/> Shortness of Breath  <input type="checkbox"/> Tremor  <input type="checkbox"/> Weakness         </div> </div>							
<b>Physical Exam (Must Be Completed by Treating Practitioner)</b>							
HE:	MC:	LSP:	Pulse (resting):	Pulse (action):			
Shortness of Breath at Rest? Y      N	Shortness of Breath w/exercise? Y      N	Is O2 required? Y      N	Number of Liters?	O2 Sat?			
Any current pressure sores? Y      N	History of pressure sores? Y      N	Location?	Stage?	Able to shift weight? Y      N			
Post Balance Y      N	Post Endurance Y      N	History of Falls Y      N	Risk of Falls Y      N	Significant Edema Y      N			
Upper Body Weakness: _____ Mild _____ Moderate _____ Severe Upper Body Pain: _____ Mild _____ Moderate _____ Severe Lower Body Weakness: _____ Mild _____ Moderate _____ Severe Lower Body Pain: _____ Mild _____ Moderate _____ Severe Cast/Casture: _____ RUE / LUE      _____ RLE / LLE			Gait Pattern: _____ Non-Ambulatory _____ Max Assist _____ Med Assist _____ Ataxic _____ Shuffling				

# Face To Face Mobility Examination Report

**Michael Rajnik**

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the name bar.

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## **Table of Contents Face To Face Mobility Examination Report**

1. Understanding the eBook Face To Face Mobility Examination Report
  - The Rise of Digital Reading Face To Face Mobility Examination Report
  - Advantages of eBooks Over Traditional Books
2. Identifying Face To Face Mobility Examination Report
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an Face To Face Mobility Examination Report
  - User-Friendly Interface
4. Exploring eBook Recommendations from Face To Face Mobility Examination Report
  - Personalized Recommendations
  - Face To Face Mobility Examination Report User Reviews and Ratings
  - Face To Face Mobility Examination Report and Bestseller Lists
5. Accessing Face To Face Mobility Examination Report Free and Paid eBooks
  - Face To Face Mobility Examination Report Public Domain eBooks
  - Face To Face Mobility Examination Report eBook Subscription Services
  - Face To Face Mobility Examination Report Budget-Friendly Options
6. Navigating Face To Face Mobility Examination Report eBook Formats

- ePub, PDF, MOBI, and More
- Face To Face Mobility Examination Report Compatibility with Devices
- Face To Face Mobility Examination Report Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Face To Face Mobility Examination Report
  - Highlighting and Note-Taking Face To Face Mobility Examination Report
  - Interactive Elements Face To Face Mobility Examination Report
- 8. Staying Engaged with Face To Face Mobility Examination Report
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Face To Face Mobility Examination Report
- 9. Balancing eBooks and Physical Books Face To Face Mobility Examination Report
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Face To Face Mobility Examination Report
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Face To Face Mobility Examination Report
  - Setting Reading Goals Face To Face Mobility Examination Report
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Face To Face Mobility Examination Report
  - Fact-Checking eBook Content of Face To Face Mobility Examination Report
  - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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