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2019 WalkAide Evaluation

Patient Name: _____

☐ Request pre-authorization package for insurance.

No pre-authorization necessary because:

☐ Medicare patient
☐ Other _____
☐ Cash patient

*******HAP*******

☐ Yes ☐ NO

Date Started:_____/2020

Stimulation Assessment	Yes	No
Dorsiflexion response to stim	☐	☐
Eversion response to stim	☐	☐

Diagnosis_____

☐ Right ☐ Left ☐ Bilateral

Clinician Information

Primary Clinician:	
Administrator (OA):	
Address:	
City, St, Zip:	
Phone #:	
Fax #:	
E-mail Address:	
6 Digit Clinic #:	

Clinician Credentials
☐ CP
☐ CO
☐ CPO
☐ BOCOP
☐ (other)_____

I have attached copies of the following information:

☐ Copy of Rx *(Detailed, signed prescription required for Medicare applications)*
☐ Letter(s) of medical necessity (verification from Physician)
☐ Medical notes

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Patient Information

Name:		Height:	
Home Address:		Weight:	
City, State, Zip:		Gender:	☐ Male ☐ Female
Home Phone:		Date of Birth:	
Other Phone:		Age:	
E-mail:			

Insurance:	☐ Medicare	☐ Medicare Replacement Plan	☐ Workers Comp
	☐ VA	☐ Private Insurance	☐ Other: _____

Name of Primary Insurance Company _____

Primary Insurance ID # _____

Secondary or Supplemental Insurance Co. _____ ☐ **Medicare** ☐ **None**

Health Related Information

Identify any related or relevant physical conditions or injuries related to foot drop:

_____

_____ Surgery (s) Date(s) _____

_____ Accident(s)/injury(s) Date(s) _____

	No	Yes
1. Does the patient have history of seizures?	☐	☐
2. Is the patient pregnant or planning to become pregnant?	☐	☐
3. Are there signs, symptoms or history of a Thrombosis?	☐	☐
4. Does the patient have a pacemaker?	☐	☐
5. Is there a history of osteoporosis?	☐	☐
6. Is there a history of skin disease or cancer in the area of stimulation?	☐	☐
7. Is there a history of irreversible contracture?	☐	☐
8. Is there a history of autonomic dysreflexia?	☐	☐

Check 1 – 2 Contact physician to request written permission for WalkAide clinical assessment
Check more than 3 and your patient is not a WalkAide candidate

Indications	**NO YES**
1. Patient diagnosis is an Upper Motor Neuron Disorder (e.g. CVA, TBI, MS, CP, Spastic Paraplegia, incomplete spinal cord injury (SCI – C1-T12).	☐ +0 ☐ +1
2. Patient is able to ambulate 25 feet with or without an assistive device.	☐ +0 ☐ +1
3. Patient can stand for 3 minutes independently.	☐ +0 ☐ +1
4. Patient can transfer independently.	☐ +0 ☐ +1
5. Patient can demonstrate sufficient hand and finger function to manipulate controls.	☐ +0 ☐ +1
6. Patient is without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis	☐ +0 ☐ +1
TOTAL SCORE	

Score = 6	*Complete the evaluation*
Score = 1-5	*Contact patient's physician to obtain written permission to perform trial.*
Score = 0	*Patient is NOT a WalkAide candidate*

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Daily Living Information

Living Status:	☐ Live Alone	☐ Live with Assistance
Living Conditions:	☐ Level Surfaces ☐ Uneven Surfaces	☐ Level Surfaces with Stairs ☐ Uneven Surfaces with Stairs
Normal Daily Activity:	Seated_____%	Standing/Walking_____%
Recreation Activities:	☐ Bicycling ☐ Long Walks ☐ Shopping ☐ Other _____	☐ Gardening ☐ Hiking ☐ Domestic Chores *(laundry, house cleaning, etc.)* ☐ Other _____

Employment Status

☐ **Employed as:** _____ ☐ Unemployed

☐ Retired ☐ Disabled ☐ Student

AFO/Brace Assessment

☐ I have never worn an AFO/Brace (if correct proceed to the 'Assistive Devices' on page #4))

☐ I wear my AFO/Brace all day

☐ I wear my AFO/Brace sometimes (Please explain why)

_____

☐ I have previously worn an AFO/Brace and no longer wear one (provide details of problems or issues and describe why it is no longer in use:

_____

_____

_____

Orthotic History

	Right Leg				Left Leg		
	YES	**NO**	If Yes, how long for?		**YES**	**NO**	If Yes, how long for?
Use of Foot Orthosis	☐	☐	_____years	Use of Foot Orthosis	☐	☐	_____years
Use of AFO/Brace	☐	☐	_____years	Use of AFO/Brace	☐	☐	_____years
Use of KAFO	☐	☐	_____years	Use of KAFO	☐	☐	_____years
Previous or ongoing Physical Therapy	☐	☐	_____months _____years	Previous or ongoing Physical Therapy	☐	☐	_____months _____years

Additional information:

_____

_____

_____

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Assistive Devices Currently Being Used

	☐ Walker	☐ Crutches	☐ Cane	☐ Wheelchair	☐ AFO/Brace	☐ None
Time used per day	_____Hours	_____Hours	_____Hours	_____Hours	_____Hours	
How long since it was first prescribed	_____years	_____years	_____years	_____years	_____years	

Falls	In the past year, have you fallen?	☐No ☐ Yes
	IF YES: How many times have you fallen?	_____Times
	Where you wearing an AFO/Brace?	☐No ☐ Yes
	Were you injured when you fell?	☐No ☐ Yes
	IF YES, describe your injuries: _____ _____ _____ _____	

Gait Analysis

Distance Walked	Time Without Assistive Device	Time with AFO	Time with WalkAide
☐ 10 Meters			
☐ Other_____			

Medical Necessity Justification

The WalkAide is clinically and medically necessary for this patient the following reasons:

Check All That Apply	*Additional Comments to Support Rationale*
☐ Improve Stability	
☐ Increase Walking Speed	
☐ Improve voluntary muscle contraction and increase voluntary motor control and coordination.	
☐ Improve Gait Pattern	
☐ Improve lower limb intrinsic muscle tone by activating muscle activity during gait	
☐ Improved activities of daily living	
☐Other_____	

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While Wearing an AFO/Brace	***Very Poor***	***Poor***	***Fair***	***Good***	***Very Good***
1. My overall balance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. My ability to change my pace while walking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. My ability to walk on uneven surfaces (rocks, gravel etc)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. My ability to walk DOWN stairs step over step	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. My ability to walk UP stairs step over step	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. My ability to walk down ramps with confidence	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. My ability walking in the home	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. My confidence walking in unfamiliar places	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9.. My endurance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. My confidence walking in large crowds	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

While Wearing My Existing AFO/Brace:	Always	Often	Sometime	Seldom	Never
1. I have experienced pain, blisters, skin abrasions, and or discomfort utilizing my AFO/Brace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. I am unable to wear some shoes because of my AFO/Brace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. I am unstable when standing or walking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Functional Assessment Without Orthosis	***Very Poor***	***Poor***	***Fair***	***Good***	***Very Good***
1. My overall balance	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. My ability to change my pace while walking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. My ability to walk on uneven surfaces (rocks, gravel etc)	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. My ability to walk DOWN stairs step over step	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. My ability to walk UP stairs step over step	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. My ability to walk down ramps with confidence	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. My ability walking in the home	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. My confidence walking in unfamiliar places	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. My endurance for walking distances	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. My confidence walking in large crowds	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

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Observational Gait Assessment - SWING PHASE

Check all that apply.

TRUNK	† **Difficulty maintaining stability** and/or effective alignment in one or more Planes	Yes ☐
PELVIS	† **Difficulty maintaining stability** and/or effective alignment in one or more Planes	Yes ☐
HIP	† **Difficulty initiating flexion** or maintaining sufficient swing phase momentum	Yes ☐
	† **Excessive rotation** (internal or external)that positions the limb poorly for weight acceptance	Yes ☐
	† **Excessive abduction or circumduction** that significantly increases energy Costs	Yes ☐
	† **Excessive adduction** that results in significant safety issues during contact with stance side limb	Yes ☐
KNEE	† **Difficulty maintaining sufficient flexion** for ground clearance	Yes ☐
ANKLE	† **Dropfoot** or difficult maintaining appropriate dorsiflexion for ground clearance	Yes ☐
	† **Equinovarus** posture that positions the limb poorly for stance	Yes ☐
Swing Phase Summary	Are a majority of these walking disruptions and safety concerns adequately addressed by their current orthotic design?	Yes ☐ No ☐ N/A ☐
	Are a majority of these walking disruptions and safety concerns more effectively addressed with the WalkAide System?	Yes ☐ No ☐

Observational Gait Assessment - STANCE PHASE

Check all that apply.

ANKLE	† **Poor positioning** of the foot/ankle to support the body weight	Yes ☐
	† **Potential for injury** to ligaments or development of contractures	Yes ☐
	† **Excessive plantarflexion** that limits forward progression over the foot/ankle	Yes ☐
	† **Excessive dorsiflexion** that decreases stance phase stability	Yes ☐
KNEE	† **Insufficient stability** during stance phase that increases energy costs and creates safety concerns	Yes ☐
	† **Excessive extension** or hyperextension that may lead to damage to ligaments and the joint capsule	Yes ☐
	† **Excessive flexion** that may lead to limb collapse	Yes ☐
HIP	† **Insufficient stability** during stance phase that increases energy costs and creates safety concerns	Yes ☐
	† **Excessive rotation** (internal or external) that positions the limb poorly during stance phase	Yes ☐
	† **Excessive abduction** that significantly increases energy costs due to the increased base of support	Yes ☐
	† **Excessive adduction** that results in significant safety issues due to the decreased base of support	Yes ☐
PELVIS	† **Difficulty maintaining stability** and/or effective alignment in one or more planes	Yes ☐
TRUNK	† **Difficulty maintaining stability** and/or effective alignment in one or more planes	Yes ☐
Stance Phase Summary	Are a majority of these walking disruptions and safety concerns adequately addressed by their current orthotic design?	Yes ☐ No ☐ N/A ☐
	Are a majority of these walking disruptions and safety concerns more effectively addressed with the WalkAide system?	Yes ☐ No ☐