



Patient Information

Name: _____ Insurance ID #: _____
 Home Address: _____ Amputation side: Left Right Bilateral
 City, State, Zip: _____ Amputation length:
 Date of Birth: _____ Age: _____ Short Mid-thigh Long
 Knee disarticulation Hip disarticulation
 Ht _____ Wt _____ Sex: Male Female Date of amputation: _____
 Home Phone: _____ Cause of amputation: _____
 Work Phone: _____ Age of current knee: _____

Health Related Information

	<i>Comments</i>
Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Heart Condition <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Joint Pain <input type="checkbox"/> No <input type="checkbox"/> Yes	_____
Muscle Pain <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/amputations: _____

Has your weight remained consistent for the past year? Yes No – Gained / Lost _____# (please circle)

Daily Living Information

Living Status Live Alone Live with Assistance
 Living Conditions Level Surfaces Level Surfaces with Stairs
 Uneven Surfaces Uneven Surfaces with Stairs
 Profession _____
 Normal Daily Activity % Seated _____% % Standing/Walking _____%
 Recreation Activities Bicycling Jogging
 Long Walks Aerobics
 Shopping Domestic Chores (gardening, house cleaning)
 Other _____ Other _____

Signature of Patient: _____ Date: _____



Prosthesis Assessment						
Patient Name: _____						
	<i>Poor</i>	<i>Fair</i>	<i>Good</i>	<i>Very Good</i>	<i>Excellent</i>	<i>Comments</i>
Comfort in the proximal brim (groin area)	<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	<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 (rocks, gravel etc)	<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 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 get muscle 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	
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 (sports)	<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: _____

Present Prosthesis

- Definitive
 Preparatory
 IPOP
 None, New Amputee*
**For new amputee, proceed to residual limb evaluation on page 5 (skip the remainder of this page).*

Assistive Devices

- Walker
 Crutches
 Cane
 None

Functional Level

- 0** – No ability or potential to ambulate or transfer.
 1 – Ability or potential to transfer or ambulate on level surfaces at fixed cadence.
 2 – Ability or potential to traverse low level environmental barriers.
 3 – Ability or potential to ambulate with variable cadence.
 4 – Ability or potential to ambulate which exceeds basic ambulating skills.

Gait Evaluation

- | | | | |
|--|---|--|----------------------------------|
| Length of Prosthesis
<i>Details</i> | <input type="checkbox"/> Short | <input type="checkbox"/> Long | <input type="checkbox"/> Correct |
| ML Stability
<i>Details</i> | <input type="checkbox"/> Lateral Shift | <input type="checkbox"/> Medial Shift | <input type="checkbox"/> Correct |
| Step Length
<i>Details</i> | <input type="checkbox"/> Short Pros. Step | <input type="checkbox"/> Long Pros. Step | <input type="checkbox"/> Correct |
| Whip
<i>Details</i> | <input type="checkbox"/> Lateral Whip | <input type="checkbox"/> Medial Whip | <input type="checkbox"/> Correct |

Gait Deviations

- | | | | |
|-------------------|------------------------------|-----------------------------|----------------------|
| Abducted Gait | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <i>Details</i> _____ |
| 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 | _____ |

Other Injuries, Observations & Comments:



Evaluation of Current Prosthetic Components

*For New Amputee
proceed to residual limb evaluation
on bottom of this page*

Patient Name: _____

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

FOOT: _____ Acceptable as is
 Needs to be replaced because: _____

KNEE: _____ Acceptable as is
 Needs to be replaced because: _____

SUSPENSION: _____ Acceptable as is
 Needs to be replaced because: _____

SOCKET: _____ Acceptable as is
 Needs to be replaced because: _____

LINER/INSERT: _____ Acceptable as is
 Needs to be replaced because: _____

Residual Limb Evaluation

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

Residual Limb Observations

Residual Limb Measurements

Distance from IT	Circumference



Prosthetic Recommendation

Patient Name: _____ needs Entire New Prosthesis
 Replacement Components Only

--Due To --

Change in Residual Limb Weight Gain Functional Level Change Irreparable Damage Normal Wear & Tear New Prosthetic Wearer

Recommended Componentry

Rationale

Foot: _____ Reduce Energy Consumption Increased Stability
 Walk on Uneven Terrain Variable Cadence
 Comments: _____

Knee: _____ Reduce Energy Consumption Increased Stability
 Variable Cadence Increased Comfort
 Comments: _____

Suspension: _____ Reduce Skin Abrasion Increased Stability
 Increased Prosthetic Control Increased Comfort
 Comments: _____

Socket: _____ Increased Control Increased Stability
 Increase Muscle Movement Increased Comfort
 Comments: _____

Liner/Insert: _____ Control Volume Change Increased Comfort
 Reduce Stress on Skin Improve Suspension
 Comments: _____

Protective Cover: Yes No Protect Internal Components Moisture Protection
 Total Contact: Yes No Increased Venous Return Increased Weight Bearing Surface
 Increased Comfort
 Comments: _____

Ultra-Lite Materials: Yes No Reduce Weight Increase Durability

General Observations & Comments



Patient Assessment Validation Evaluation Test

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. Amputated side hip extension <i>(Bilateral AK patient... Left side hip extension)</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. Sound side hip extension <i>(Bilateral AK patient... Right side hip extension)</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. Sound side knee extension <i>(Bilateral AK patient... score 4)</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. Sound side Ankle Planter/Dorsi Flexion <i>(Bilateral AK or AK/BK patient... score 4)</i>	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. Upper Extremity Strength	<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. Low Back or Hip Pain					<input type="checkbox"/> 1
26. Normal or Long Transtibial on contra lateral side <i>(greater than 5" tibial length)</i>					<input type="checkbox"/> 2
27. Hip disarticulation or Hemipelvecotomy on affected side					<input type="checkbox"/> 2
28. Impaired Vision					<input type="checkbox"/> 2
29. Short Transtibial on contra lateral side <i>(less than 5" tibial length)</i>					<input type="checkbox"/> 3
30. Trans Femoral on contra lateral side (bilateral AK)					<input type="checkbox"/> 3
31. 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)



Medical Necessity Verification		Patient Name: _____
Medically necessary care is justified and validated based upon the patient meeting the six 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 microprocessor knee prosthesis.</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 Microprocessor knee mechanism is established as accepted and routinely prescribed prosthetic option for functional level 3 individuals with a trans-femoral amputation; 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 microprocessor knee for functional level three (FL3) transfemoral amputees as an effective prosthetic treatment. With Medicare approval of the C-Leg and subsequent approval of L-Codes L5847 & L5989ⁱ on January 1, 2002, and the L5848ⁱⁱ on January 1, 2003. Medicare condensed these codes in January 2005 to a single code L5856. Combined with FDA approval and the VA fitting guidelines and criteria, the C-Leg knee mechanism has 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>By comparison to mechanical knee mechanisms, the Microprocessor Knee is technically more difficult and at times may be inconvenient for both the patient and the provider. For the patient, the knee must be plugged in each night so the batteries can re-charge; non-microprocessor knee units do not require this process. For the practitioner, the Microprocessor Knee involves advanced training to program the knee 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 patient is not involved in any research programs regarding their prosthesis with Hanger Prosthetics and Orthotics and to the best of your knowledge is not involved with prosthetic research programs with any other organization.</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) transfemoral amputee capable of variable cadence and ambulation on uneven terrain, Patient meets Hanger and Medicare guidelines and is considered a candidate to be fit with a microprocessor knee</i></p>

Practitioner Name Printed

Date

Practitioner Signature

NPI Number

Date

ⁱ L5847: Addition, endoskeletal knee-shin system, microprocessor control feature, stance phase

L5989: Addition to lower extremity prosthesis, endoskeletal system, pylon with integrated electronic force sensors

ⁱⁱ L5848: Addition to lower extremity prosthesis, endoskeletal system, adjustable extension dampening feature