PAVET™.2

Patient Assessment Validation Evaluation Test

BlueCross BlueShield of Montana

Patient Information

Name: _____

Home Address: _____

City, State, Zip: _____

Home Phone: _____

Other Phone: _____

e-mail: _____

Height: _____

Weight: _____

Sex: ☐Male ☐Female

Date of Birth: _____

Age: _____

Health Related Information

			If yes, where?
Diabetes	☐No ☐ Yes	Joint Pain	☐No ☐ Yes_____
Heart Condition	☐No ☐ Yes	Muscle Pain	☐No ☐ Yes_____
High Blood Pressure	☐No ☐ Yes	Back Pain	☐No ☐ Yes_____
Medication(s)	☐No ☐ 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:	☐ Level Surfaces	☐ Level Surfaces with Stairs
	☐ Uneven Surfaces	☐ Uneven Surfaces with Stairs
Normal Daily Activity:	Seated _____%	Standing/Walking _____%
Activities of Daily Living:	☐ Bicycling	☐ Gardening
	☐ Long Walks	☐ Hiking
	☐ Shopping	☐ Domestic Chores *(Laundry, house cleaning etc.)*
	☐ Other _____	☐ Other _____
	☐ Other _____	☐ Other _____

Employment Status

☐ **Employed as:** _____ ☐ Unemployed

☐ Retired ☐ Disabled ☐ Student

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Prosthesis Assessment

Patient Name: _____

	Poor	Fair	Good	Very Good	Excellent	*Comments*
Comfort in the top of the socket	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Comfort in the distal end of the socket	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Suspension	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Ease of getting the socket on	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Ease of getting the socket off	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Overall comfort of the socket	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Ability of the knee to keep up with my walking speed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Ease of standing up out of a chair	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Ease of sitting down into a chair	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My overall balance with the prosthesis	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My confidence walking in large crowds	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My confidence walking in unfamiliar places	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My overall confidence using the prosthesis	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My ability to walk at a slow speed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My ability to walk at a fast pace	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My ability to jog/run	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My ability to change speeds while walking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My stability on uneven surfaces *(rocks, gravel, etc.)*	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My ability to walk down stairs step over step	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
My ability to walk down ramps with confidence	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Weight of my prosthesis	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Cosmetic look of the prosthesis	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Cosmetic look of the knee in a seated position	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Prosthetic shape resembles my sound side	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Fit of the prosthetic foot in the shoe	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	

Patient's Initials _____ Date _____

Activity & Comfort Assessment

Patient Name: _____

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

Patient's Initials _____ Date _____

Patient Name: _____

Amputation Details

Left Side Amputation ☐ None

☐ AK ☐ Hip/Hemi ☐ KD
☐ BK ☐ Partial Foot ☐ Upper Limb
Limb Length ☐ Short ☐ Mid-thigh ☐ Long

Cause of Amputation: _____
Date of Amputation: _____
Age of Prosthesis: _____

Right Side Amputation ☐ None

☐ AK ☐ Hip/Hemi ☐ KD
☐ BK ☐ Partial Foot ☐ Upper Limb
Limb Length ☐ Short ☐ Mid-thigh ☐ Long

Cause of Amputation: _____
Date of Amputation: _____
Age of Prosthesis: _____

Assistive Devices Currently Being Used

☐ Walker ☐ Crutches ☐ Cane ☐ Wheelchair ☐ None

Functional Level

☐ K0	☐ K1	☐ K2	☐ K3	☐ K4
No ability or potential to ambulate or transfer.	Ability or potential to transfer or ambulate on level surfaces at fixed cadence.	Ability or potential to traverse low level environmental barriers.	Ability or potential to ambulate with variable cadence.	Ability or potential to ambulate which exceeds basic ambulating skills.

Present Prosthesis

☐ Definitive ☐ Preparatory ☐ IPOP

☐ None, New Amputee*
skip the remainder of this page proceed to residual limb evaluation on page 5

Gait Evaluation

Length of Prosthesis	☐ Short	☐ Long	☐ Correct
	Details: _____		
ML Stability	☐ Lateral Shift	☐ Medial Shift	☐ Correct
	Details: _____		
Step Length	☐ Short Pros. Step	☐ Long Pros. Step	☐ Correct
	Details: _____		

Gait Deviations

Abducted Gait	☐ Yes	☐ No	_____
Circumducted Gait	☐ Yes	☐ No	_____
Vaulting	☐ Yes	☐ No	_____
Knee Instability	☐ Yes	☐ No	_____

Falls

In the past year, have you fallen while wearing your prosthesis? ☐ No ☐ Yes

IF YES: How many times have you fallen? _____ Times

Were you injured when you fell? ☐ No ☐ Yes

IF YES, describe your injuries: _____
_____

Other Injuries, Observations & Comments:

Evaluation of Current Prosthetic Components

For New Amputee; proceed to residual limb evaluation on this page

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	☐ Normal	☐ Discoloration	☐ Open Wounds	
Details				
Limb Shape	☐ Normal	☐ Bulbous	☐ Conical	
Details				
Contracture	☐ Flexion	☐ Abduction	☐ None Present	
Details				
Other	☐ Scars	☐ Bony Prominence	☐ Neuroma	
Details				

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*			
	☐ Prosthetic Knee Instability (AK only)	☐ New Prosthetic Wearer	☐ Change in Residual Limb
		☐ Functional Level Change	☐ Normal Wear & Tear
	☐ Irreparable Damage	☐ Weight Gain # of lbs._____	☐ Weight Loss # of lbs. _____

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

General Observations & Comments:

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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*	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Walk a distance greater than 400 yards*	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Walk on uneven terrain (gravel, grass, curbs)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Walk up and down stairs	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Walk up and down ramps	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. Carry or lifting items	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. Walk in public areas or crowds*	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. Get in and out of a car	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. Bending, kneeling or stooping	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. Walk, stand or work in confined areas	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Functional Capabilities

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

Prosthetic Reliance Evaluation

Patient Limb/Joint Strength:	Normal	Good	Fair	Poor	Trace
16. Right side hip extension	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17. Left side hip extension	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18. Right side knee extension *(AK on Right side… score 4)*	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19. Left side knee extension *(AK on Left side… score 4)*	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20. Sound side ankle plantar/dorsi flexion *(Bilateral AK or AK/BK patient… score 4)*	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Special Consideration Evaluation

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

ADL Score	Functional Score	Reliance Score	Special Score	Total

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

Patient Name: _____

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Medical Necessity Verification

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

☐ Yes	☐ No	**Medically Necessary care and treatment is recommended or approved by a Physician** *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.*
☐ Yes	☐ No	**Is consistent with the patient's condition or accepted standards of good medical practice** *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.*
☐ Yes	☐ No	**Is medically proven to be effective treatment of the condition** *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.*
☐ Yes	☐ No	**Is not performed mainly for the convenience of the patient or provider of medical services** *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.*
☐ Yes	☐ No	**Is not conducted for research purposes.** *By answering "Yes" this confirms that the above listed individual is not involved with any research programs regarding his or her prosthesis.*
☐ Yes	☐ No	**Is the most appropriate level of service which can be safely provided to the patient** *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.*

_____
Clinician Name Printed

_____ _____
Clinician Signature *Date*