

## URGENT REQUEST



12/30/25 RE-FAX

Date: 12/19/25 Client: Sandra Matteo DOB: 06/16/1967 Order#: 13067645

To: AMANDA KELIIHOOMALU, NP Numotion Contact: Katie Mullins

Attention: Phone: (859) 618-6732 Ext:

Fax: (833) 450-4801 RETURN FAX:

Phone: (615) 274-9767

**(855) 950-1477**

URGENT

TOTAL PAGES:

9

ORDER TYPE:

Rehab

Subject: POWER MOBILITY DEVICE

**IMPORTANT: \*\*\* PLEASE RETURN THIS FAX COVER SHEET WITH YOUR RESPONSE \*\*\***

*(This fax cover sheet includes a barcode that will reduce processing time by automatically attaching the received documents to the patient's order)*

**PMD Standard Written Order**

\* This document must be completed entirely by the Practitioner  
who completed the Face to Face Evaluation

\*\*\*\*\* \* CMS requires this document to be completed entirely by hand  
or entirely using a system/software protected against  
modification

\* Printed Name OR NPI must be completed, all remaining fields  
required

\*\*\*\*\*

Numotion received Face to Face Chart Notes reflecting an exam performed: **10/7/2025**

**PLEASE REVIEW THE FOLLOWING DOCUMENTATION ATTACHED:**

- 1.) Review attached PT/OT Evaluation. If you concur, please sign, date and return.
- 2.) **PMD Standard Written Order (See Note Below)** Please be sure to add an actual description on the 2nd line
- 3.) **Please Sign and Date the Practitioner's Standard Written Order (PSWO)**  
**If paperwork is completed electronically EACH document must have a statement that it was completed that way. If not, everything must be completed by hand.**

**\*\*NOTE: Documents must be completed by the Practitioner who conducted the Face to Face Examination\*\***

**If you have any questions please feel free to contact us at the number above.**

**Thank you for your assistance!**



\*13067645\$042\$\$\$\*

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- Provides access to you and your team to complete and track the progress of forms, documents and charts.
- Decreases processing time by cutting down on lost and illegible/unusable documents.

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DoctorSetup@numotion.com and we can help tailor  
an eSign solution for your needs.



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  - **The signing clinician's direct email address.**  
(To ensure this process is compliant, this must be the practitioner's solo email address and not a shared/group address.)
  - **The name and email address of any team that will be assisting.** We recommend you include additional staff that may be able to assist with completing any forms insurance allows, printing completed documents for charting, helping track for completion, etc.
- 2) When there are documents waiting for your signature you'll get an email (similar to the image below) notifying you the documentation is ready to sign.
- 3) Click **Review Document** to sign-in and follow the prompts to complete and sign. Each of the required fields will be clearly labeled.
- 4) When completed, documents will be sent back to the Numotion Documentation Team and a link to the completed forms will be emailed to you.





## Plan of Care

**Date of Visit:** 12-11-25  
**Patient Name:** Matteo, Sandra  
**Patient #:** 3907436  
**Date of Birth:** 06-16-1967  
**Age:** 58

**Therapist:** Julia Timms, PT  
**Referring MD:** Self Referred,  
**Certification Period:** 12-11-25 - 12-11-25  
**Case:** PT001

**Date of Onset:** 10-11-11

**Diagnosis:**  
M62.81 Muscle weakness (generalized)

Scheduled appointments during reporting period: 2  
Completed treatment sessions: 1  
Missed treatment sessions: 1

### SUBJECTIVE:

#### Presenting Problems:

##### Location of pain:

Pain was not assessed in this wheelchair evaluation.

##### Subjective Comments:

Home Environment: lives with spouse, 6 hours without assistance, does have a home health aid come to the home when spouse is not home, 3 stairs to enter home, but once inside, everything is on the first floor, no ramps in the house

##### Systems Review:

Autonomic system: hx of POTS with 2-4 syncope episodes a week.

Cardiac status: decreased endurance; pt requires a daily saline infusion to manage blood pressure

Respiratory status: decreased endurance

Falls in last 12 months: almost daily syncope episodes that can lead to falls if she is not in a safe position

Injuries related to falls: head injuries

Skin History: hx of skin lacerations from falls.

Edema: significant LE edema

Neuropathy: in B feet

Patient: Sandra Matteo, DOB: 06-16-1957

2197 Madison St Ste 106 Clarksville, TN 37043-5284  
Phone: (931) 503-1700 Fax: (931) 994-5631  
Part of the Upstream Rehab Family of Clinical Care

## PHYSICAL THERAPY PLAN OF CARE CONTINUED

**Date of Visit:** 12-11-25  
**Patient Name:** Matteo, Sandra  
**Patient Number:** 3907436  
**Date of Birth:** 06-16-1967

**Referral Source:** Self Referred,  
**Date of Onset:** 10-11-11  
**Certification Period:** 12-11-25 - 12-11-25  
**Case:** PT001

### ASSESSMENT:

Matteo was evaluated today for a power mobility device. She presents with a primary diagnosis affecting mobility of COPD, parkinson's disease, EDS, and POTS. She reports functional difficulties with ADLs in her home including ambulating to the restroom as well as with preparing meals for herself. Based on this evaluation her mobility limitation cannot be resolved by the use of an appropriately fitted cane or walker due to decreased safety and balance secondary to multiple syncope episodes from hypotensive episodes, resulting in falls. She is non-ambulatory, and is a fall risk for ambulating any distance independently based on decreased balance and endurance. Her mobility limitation cannot be resolved by the use of an optimally configured high strength lightweight manual wheelchair due to decreased UE strength and endurance to propel the wheelchair forward. She is unable to propel a high strength lightweight manual chair due to decreased UE strength and endurance, and is unable to propel the wheelchair forward. Her mobility limitation cannot be safely and sufficiently resolved by the use of a scooter due to being a fall risk for getting on and off the device, and due to the turning radius of the device being too large for her home. A Power wheelchair will significantly improve her ability to participate in MRADLs, and she is willing to use a power wheelchair, as it will allow her safe, full time mobility between rooms of her home, as well as the ability to perform self care and meal preparation activities safely from a seated position. Along with the wheelchair, she will require power tilt due to high risk of skin break down, hypotensive episodes, power elevating leg rests due to blood pooling from EDS and LE edema, 4-point chest harness due to syncope episodes and to limit risk of falling out of the chair, IV pole to assist with her saline infusions and minimize risk of falls from transferring from wheelchair to bed, head rest with hardware to support her head and neck, battery to power the wheel chair, and skin protection cushion to limit risk of skin break down. She will also require expandable electronics with harness in order to control the wheel chair, and a swing away joystick in order to navigate the wheelchair and for clearance to table for meal times. She displays sufficient mental and physical capability to safely operate a power wheelchair.

She is aware of her diagnosis. The plans and goals have been developed and discussed with the patient.

### REHAB POTENTIAL:

The patient's rehab potential is fair.

### PLAN/RECOMMENDATIONS:

The patient's treatment will include PT Eval High Complexity, Recommend Power Wheelchair, Ther-Ex / Procedure, Therapeutic Activity, Self Management, Wheelchair Management and neuromuscular re-education. Patient was seen for one time visit for wheelchair assessment. No follow up visits are recommended at this time. The patient will be seen 1 time per week for 1 week, for a total of 1 visit.

Patient/caregiver of patient has consented to treatment and understands the diagnosis, prognosis and treatment goals associated with this plan of care.

### OBJECTIVE:

### PT NEUROLOGICAL EVALUATION

### RANGE OF MOTION:

Upper Extremity	Initial
Right AROM	12-11-25
Shoulder Flexion (180)	90
Shoulder Extension (50-60)	45
Shoulder Abduction	90

Patient: Sandra Matteo, DOB: 06-16-1967

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## PHYSICAL THERAPY PLAN OF CARE CONTINUED

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**Date of Onset:** 10-11-11  
**Certification Period:** 12-11-25 - 12-11-25  
**Case:** PT001

(180)	
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Upper Extremity	Initial
Left AROM	12-11-25
Shoulder Flexion (180)	90
Shoulder Extension (50-60)	45
Shoulder Abduction (180)	90

**MANUAL MUSCLE TEST:**

Upper Extremity	Initial
Right MMT	12-11-25
Shoulder Flexion	3+
Shoulder Extension	3
Shoulder Abduction	4

Upper Extremity	Initial
Left MMT	12-11-25
Shoulder Flexion	3
Shoulder Extension	3
Shoulder Abduction	3+

Lower Extremity	Initial
Right MMT	12-11-25
Hip Flexion	3
Knee Extension	3
Knee Flexion	3
Ankle Dorsiflexion	4

Lower Extremity	Initial
Left MMT	12-11-25
Hip Flexion	3
Knee Extension	3
Knee Flexion	3
Ankle Dorsiflexion	4

**Muscle Function:**

Functional Strength Tests:

Chair Push-Up: unable

Trunk - Can the patient obtain and maintain an upright posture against gravity? Require use of one hand/arm to support in sitting.

Head/Neck Supine - Can patient lift and hold head from support surface? Yes How Long? Approximately 10 sec

Head/Neck Sitting - Can patient obtain and maintain neutral head positon? Yes If not, why? Approximately 10 sec

**POSTURE:**

Determine if postural abnormalities are Reducible or Non-Reducible:

Can the patient move or be moved to correct the postural abnormality? (CHOOSE ONE AND DELETE OTHERS)

- No: Patient has a non-reducible or fixed deformity --> Accommodate
- Yes: Patient has a reducible or flexible deformity --> Correct

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## PHYSICAL THERAPY PLAN OF CARE CONTINUED

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**Date of Onset:** 10-11-11  
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- Somewhat: Patient has a partly reducible deformity → Correct what is correctable, accommodate the rest

Function/ADLs	Rating	Comments
Functional Mobility	Dependent	
Bed Mobility	Dependent	
Transfers	Dependent	
W/C Propulsion	Dependent	

Sensory	Rating
Light Touch UE	Impaired
Light Touch LE	Impaired

Figure 8	53.5 cm		54 cm	
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### Edema Comments:

1+ pitting edema B

### GENERAL OBJECTIVE COMMENTS:

#### Skin Assessment:

1. Visual Inspection, including stage/location of any open area - note if any of these areas are in contact with the wheelchair or seating components:

2. Pressure Relief Method(s): (DELETE THOSE THAT DO NOT APPLY)

Lean side to side to offload (without risk of falling)

W/C push up (4+ times/hour for 15+ seconds)

Stand up (without risk of falling)

Other: assisted transfers

Effective pressure relief method(s) above can be performed consistently throughout the day:

[ ] Yes

[ x ] No (If no, why? decreased strength, risk of syncope episode, decreased endurance)

Goals	Short-Long	Time Frame	Result	Comment	Last Assessed
A one time mobility assessment will be performed	Short Term	One visit	Met		
Patient will obtain a power wheelchair to aid mobility and decrease pain and fall risk	Short Term	One Visit	Met		

Thank you for your referral. We will keep you updated on this patient's progress.

### TO BE COMPLETED BY PHYSICIAN:

Patient: Sandra Matteo, DOB: 06-16-1967

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## PHYSICAL THERAPY PLAN OF CARE CONTINUED

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**Certification Period:** 12-11-25 - 12-11-25  
**Case:** PT001

I hereby certify that rehabilitation services are medically necessary for the above mentioned. I also understand that my signature signifies agreement with the plan.

\_\_\_\_\_  
Self Referred, Signature

\_\_\_\_\_  
Date

PLEASE SIGN & DATE

Please sign the above Progress Note and return to:  
Results PT - Clarksville-Sango, TN  
2197 Madison St Ste 106  
Clarksville, TN 37043-5284

Phone: (931) 503-1700  
Fax: (931) 994-5631

Best regards,

Julia Timms PT

This document was electronically signed on 12-13-25 at 05:58p by Julia Timms PT.

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**PMD Standard Written Order**

**Patient Name:** \_\_\_\_\_

**Description of Equipment Ordered:** \_\_\_\_\_

**Treating Practitioner Signature:** \_\_\_\_\_

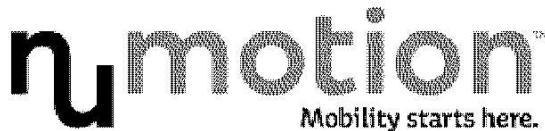
**Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**NPI:** \_\_\_\_\_



\*13067645\$\$042\$\$\$\*



## **Practitioner Standard Written Order**

161 Bain Dr Ste F  
La Vergne, TN 37086-3611

**Therapist:** Julia Timms, RESULTS PHYSIOTHERAPY  
**Phone:** (931)503-1700

**Order Date:** 12/19/2025  
**Client:** Sandra Matteo  
**Address:** 1065 Willow Cir  
**City St. Zip:** Clarksville, TN 37043  
**Phone:** (402)953-7731  
**Birthdate:** 6/16/1967  
**Order #** 13067645

Vendor	Part #	Description	Code	UOM	Qty
Pride Mobility Products	J4E 2SP-SS	PWC gp2 std sing pow opt s/b	K0835	EA	1
Pride Mobility Products	BAT2004376	22 NF sealed lead acid battery	E2361	EA	2
Pride Mobility Products	ACC2201042	S/A Rem Retr Joystick/Drive Ct	E1032	EA	1
Pride Mobility Products	PTOINDV3882	Pwr Seat Tilt	E1002	EA	1
Pride Mobility Products	PTOINDV4009	Pwr seat elev sys for crt	E2298	EA	1
Pride Mobility Products	CP10CCSPM	CUSTOM HEADREST	E0955	EA	1
Pride Mobility Products	ST-HMO475-17M-Q	S/A Rem. Retr. Headrest	E1033	EA	1
Pride Mobility Products	XRF000002	Expandable controller, initl	E2377	EA	1
Pride Mobility Products	XRF000264	PWC harness, expand control	E2313	EA	1
Pride Mobility Products	XRF000336	Electro connect btw 2 sys	E2311	EA	1
Pride Mobility Products	TC2-VNC1818	Skin pro/pos w/c cus wd <22"	E2607	EA	1
Pride Mobility Products	PTOINDV3754	PWR Center Mount Elev Legrest/	E1012	EA	1

<b>Diagnosis:</b>	G90A	Postural orthostatic tachycardia syndrome [
	R531	Weakness
	M329	Systemic lupus erythematosus, unspecified
	R296	Repeated falls

**Prescribing Practitioner:**  
**Name:** Amanda Keliihoomalu, NP  
**Address:** 9019 Overlook Blvd Ste C1B  
**City St Zip:** Brentwood, TN 37027-2737  
**Phone:** (615)274-9767 **Ext:**           **Fax:** (833)450-4801  
**NPI:** 1972313880  
**Dr License #**       37641

**Length Of Need:** Lifetime

**Practitioner Signature:** \_\_\_\_\_ **Signature Date:** \_\_\_\_\_



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