walkasins® CLINICAL ASSESSMENT

Place Copy in Patients Medical Chart

PATIENT INFORMATION

Patient Name:	Date of Birth:	Gender:
Street Address: City/State/Zip	Patient Primary Phone:	☐ Home ☐ Cell

Shoe Size *(US)*: ☐ Men's ☐ Women's	Foot Width: *(in mm)*	Walkasins Foot Pad Size ☐ Small ☐ Large	Height:	Weight:

GAIT AND BALANCE IMPAIRMENTS *(Check all that apply)*

☐ Abnormalities of gait and mobility (R26)
☐ Difficulty in walking, not elsewhere classified (R26.2)
☐ Unsteadiness on feet (R26.81)
☐ Unspecified abnormalities of gait and mobility (R26.9)
☐ Repeated falls (R29.6)

ASSISTIVE DEVICES USED (*Check all that apply)*

☐ None ☐ Cane ☐ Walker ☐ Other: _____

FALL HISTORY

Fallen in Last Year?
___Yes
___ No

If Yes:
___ 1 Fall without Injury
___ 1 Fall with Injury
___ ≥ 2 Falls

Fall Risk Level:
___ Low
___ Moderate
___ High

BALANCE ASSESSMENTS *(Complete for any performed within last 12 months)*

	Score	Date		Score	Date
Gait Speed:	_____	_____	30 Second Chair Stand:	_____	_____
FGA:	_____	_____	4 Stage Balance Test:	_____	_____
TUG:	_____	_____	Other:	_____	_____

RESULTS OF WALKASINS IN-CLINIC EVALUATION

☐ Patient has demonstrated ability to feel tactile stimuli from Leg Unit
☐ Patient has completed an assessment and successful trial of Walkasins
☐ Patient has demonstrated the functional capability for use of Walkasins, including donning and doffing

NOTES

CLINICIAN CERTIFICATION AND SIGNATURE

I completed a demonstration with Walkasins with the above named patient and the information provided is true and accurate to the best of my knowledge.

Clinician's Name	Facility / Clinic
Clinician's Signature	Date

Fax this form to RxFunction Customer Service to **844-925-5279**