LON

Level of Need Assessment Form

Facility Fax #:

Dear Medical Professional:

Our office has received a request for non-emergency medical transportation for one of your patients. This form will be used to determine the patient's most appropriate mode of transportation based on their functional abilities and limitations, including whether your patient is able to use public transportation. Your input in completing this form is critical to ensure patients receive the correct mode of transportation. **Please fill out this Level of Need Assessment (LON) form legibly and completely, providing supporting information as needed and return to MTM as soon as possible.**

Patient Information	First Name:	Last Name:	Date of Birth:	
	Medical ID #:	Phone #:	Trip #:	
	Address:	City:	State:	Zip:
Physical Abilities and Equipment	Does the patient use any of the following assistive devices? ☐ Walker ☐ Crutches ☐ Cane ☐ Portable Oxygen ☐ Service Animal ☐ Manual Wheelchair ☐ Medical Leg Brace ☐ Electric Wheelchair or Scooter [weight:] ☐ Bariatric Wheelchair [weight:] ☐ None			
	Does the patient require assistance of trained personnel for safety in order to effectively use the assistive devices? ☐ Yes ☐ No			
	Can the patient self-transfer from a wheelchair? ☐Yes ☐ No	Can the patient remove themselves from unsafe situations? ☐Yes ☐ No		
	Do environmental factors like heat or cold affect the patient's mobility to where they would not be able to use a particular mode of transportation during certain seasons? ☐ Yes (please explain): ☐ No			
Cognitive/ Sensory Abilities	Does the patient have limitations with any of the following that would affect their ability to use a particular mode of transportation? **Vision**: ☐ No ☐ Yes **Hearing**: ☐ No ☐ Yes **Alertness**: ☐ No ☐ Yes **Confusion**: ☐ No ☐ Yes **Memory Issues**: ☐ No ☐ Yes			
Mental and Behavioral Health	Does the patient have any mental/behavioral health limitations that would affect the their ability to use a particular mode of transportation? ☐ Yes ☐ No			
Pregnancy	Is the patient pregnant and experiencing complications that would classify their pregnancy as high risk? ☐ Yes ☐ No			
Transportation Certification Timeframe	Transportation limitation is: ☐ Temporary Through (date): ☐ Permanent* ** Only select permanent if the patient's condition <u>will not</u> improve.*			
Additional Comments:				

Medical Professional Information	Printed Name and credentials:		Phone #:
	Signature:	Date:	Facility or Individual NPI#: *If applicable.*

Questions? Please contact MTM at 1-888-561-8747.
Please fax this **completed** form to: **1-877-406-0658, ATTN: Level of Need**