Send completed packet to: Myomo Reimbursement
Fax: 440-815-2233 Email: reimbursement@myomo.com

MyoPro Evaluation – For O&P Clinician

Patient Name: _____

Date of Evaluation: _____

☐ Insurance authorization packet to be completed

☐ Patient does not require insurance authorization because:

_____

O&P Practice Information

O&P Clinician (Include Credentials): _____

Practice: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Fax Number: _____

O&P Clinician Email: _____

Practice Insurance Specialist and Contact Info: _____

_____

Attachments to the Evaluation Packet

☐ *Verification of Insurance Benefits* form ☐ Signed Patient *Release of Med Records*
☐ *Patient Questionnaire* ☐ *DASH Questionnaire* ☐ Patient Photos ☐ EMG graphs

_____

Patient Name: _____ PN 2225 Rev 7

History: Please first ensure that the patient's *Release of Medical Records* is signed and the *Patient Questionnaire* is completed. (To save time, the patient may attempt this on their own.) Are there any gaps in the information requested?

☐ NO → proceed to fill out the rest of this form.

Diagnosis		
Affected Side: ☐ Left ☐ Right ☐ Bilateral		
Date of On-Set:		
Primary Diagnosis: Underlying cause of hemiparesis or upper extremity impairment as diagnosed by the referring physician. List ICD-10 if known.		
☐ _____ - CVA/Stroke	☐ S14.3 - Brachial Plexus Injury	☐ G35 - Multiple Sclerosis
☐ _____ - Spinal Cord Injury	☐ _____ - Cerebral Palsy	☐ S06 - Traumatic Brain Injury
☐ G12.21 - Amyotrophic Lateral Sclerosis (ALS)	☐ Other: _____	

Detailed Orthotic History (Select all the patient has used, corroborate with answers on *Patient Questionnaire*, pg 4.)
☐ Resting WHFO ☐ Dynamic WHFO ☐ Resting EO ☐ Dynamic EO ☐ FES Unit ☐ Other(s) _____ _____ Additional comments on success or failure of these orthoses:

Help the patient complete the DASH Exam, attached: Myomo staff will calculate score.

Physical Exam:

Resting Position (Check all that apply.)	
Shoulder	☐ Neutral ☐ Flexed ☐ Extended ☐ Internal Rotation ☐ External Rotation
Elbow	☐ Flexed ☐ Extended
Forearm	☐ Neutral ☐ Pronated ☐ Supinated
Wrist	☐ Neutral ☐ Flexed ☐ Extended ☐ Ulnar Deviation ☐ Radial Deviation
Hand	☐ Neutral ☐ Flexed ☐ Extended

Shoulder Subluxation (Select 1 description of shoulder stability, +/- harness requirement.)
☐ No subluxation ☐ 1 Finger width ☐ 2 Fingers ☐ 3 Fingers ☐ Fully Dislocated

Quantify passive ROM & grade any spasticity of weak arm with *Modified Ashworth Scale*:

Grade	Description
0	No increase in muscle tone
1	Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end range of motion when the affected parties moved in flexion or extension
1+	Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder (less than half) of the range of motion
2	More marked increase in muscle tone through most of the range of motion, but the affected part is easily moved
3	Considerable increase in muscle tone, passive movement is difficult
4	Affected part is rigid in flexion or extension

Modified Ashworth Scale (MAS) Spasticity Score: Grade as 0-4	
Biceps:	Triceps:
Wrist/Finger *Flexors*:	Wrist/Finger *Extensors*:

Passive ROM°	Shoulder		Elbow		Wrist		Fingers: Flex/Ext Thumb: Palmar Abd/Adduction	
	Left ☐WNL*	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL
Flex	°	°	°	°	°	°	°	°
Extend								
Abduct								
Adduct								

*WNL = Within Normal Limits, does not require detailed measurements.

Grade arm strength on the standard 0-5 scale, as described below:

Grade 5	Normal power
Grade 4	Active movement against gravity with resistance
Grade 3	Active movement against gravity without resistance
Grade 2	Active movement with gravity eliminated
Grade 1	Only a trace or flicker of movement
Grade 0	No movement

Strength	Shoulder		Elbow		Wrist		Fingers: Flex/Ext Thumb: Palmar Abd/Adduction	
	Left ☐ WNL*	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL
Flex	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5
Extend	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5	____ / 5
Abduct	____ / 5	____ / 5					____ / 5	____ / 5
Adduct	____ / 5	____ / 5					____ / 5	____ / 5

*WNL = Within Normal Limits, does not require detailed measurements.

EMG Testing: Place EMG sensors over biceps and triceps (most robust muscle activity areas) and, if needed, over forearm flexors and extensors (**distal 2/3 of forearm**). Ask the patient to fire these muscle groups one set at a time, note the EMG response, and print a graph (if available) showing their best effort. An *adequate* signal is one that is sustainable (~2 seconds) and repeatable (~10 repetitions) before fatigue limits the effort.

Indicate whether functional EMG signals are found over target muscle groups, & attach graph.	
Biceps: ☐ Not tested ☐ Adequate EMG ☐ Inadequate EMG	Triceps: ☐ Not tested ☐ Adequate EMG ☐ Inadequate EMG
Forearm *Flexors:* ☐ Not tested ☐ Adequate EMG ☐ Inadequate EMG	Forearm *Extensors*: ☐ Not tested ☐ Adequate EMG ☐ Inadequate EMG

Botox-use note: If candidate is currently receiving Botox in the muscles being tested, EMG may be temporarily impaired. Evaluation should come at least 2 weeks since last treatment.

Active ROM Photographs – To Be Completed By O&P Clinician

Please take digital photos of the patient in the poses listed and demonstrated below. Each shot should be perpendicular to the plane of motion being examined in affected arm(s), as demonstrated in the example photos below. Myomo staff will determine goniometer measurements of the active ranges of motion based on your photos. *Position the patient to eliminate gravity for any shot where strength is 2:5 or less, to demonstrate max range despite this weakness.

Needed poses:

1. Whole body, straight-on, from the knees up, with patient's face showing, smiling.
2. Shoulder – max active abduction (*bilateral*), flexion, extension.
3. Elbow – max active flexion, extension.
4. Wrist – max active flexion, extension.
5. Hand (all digits) – max active flexion (close grasp), extension (open grasp).
6. Thumb only – max active palmar adduction, palmar abduction.

+ Any other shots helpful to illustrate patient condition (e.g. close of up related scars)

AROM Photo examples:

1. 

2. 

Patient Name: _____

AROM Photo Examples (continued):

3. 

4. 

5. 

AROM Photo Examples (continued):

6. 

*Example of gravity-eliminated pose for wrist / hand motions with <3:5 strength:

Almost done! *Based on the above exam***,** you now know what kind of MyoPro the patient qualifies for. Please review the inclusion / exclusion criteria below, and indicate which device you are recommending.

Physical Criteria Checklist	
Body Dimensions and Size (approximations) ☐ Height: Min = 5 ft Max = 6 ft 4 in ☐ Weight Min = 110 lbs Max = 250 lbs ☐ Forearm circumference (widest) Min = 8 in Max = 13 in ☐ Bicep circumference Min = 9 in Max = 15 in ☐ Upper arm length Min = 5.5 in Max = 10.5 in (elbow bent 90°, elbow crease to axilla) ☐ Wrist thickness (antero-posterior) Min = none Max = 2.5 in ☐ Forearm length (elbow to wrist center) Min = 9 ¾ in Max = 12 in Personal ☐ Intact cognition ☐ Highly motivated, appropriate goals, willing to attend therapy ☐ Good caregiver/family support as needed for care and use of device Shoulder ☐ Min active shoulder flexion >30° and abduction >20°. (If not, can the candidate accept function with elbow held down at the side?) ☐ Max shoulder subluxation of 2 finger widths ☐ No uncontrolled shoulder pain Elbow ☐ Adequate EMG signal in biceps **or** triceps ☐ Minimal passive range of motion from –30° extension to 110° flexion, without pain. (If existing contractures prevent this, seek guidance from OT about interventions to resolve before fitting.) ☐ None to moderate elbow flexor/extensor tone, ≤ 3 M.A.S. ☐ If using Botox, candidate understands this drug can be useful for pre-fitting spasticity reduction, but may interfere with MyoPro function if continued long term after fitting.	Criteria for all MyoPros: models Motion E, W, and G.
Wrist/Fingers ☐ Adequate EMG signal in wrist/hand flexor **or** extensor groups ☐ Passive range of wrist to neutral *while fingers in extension*, without pain ☐ None to mild flexor/extensor tone: ≤ 2 M.A.S. ☐ If using Botox, candidate understands this drug can be useful for pre-fitting spasticity reduction, **but** may interfere with MyoPro function if continued long term after fitting.	Additional criteria for Motion G only

MyoPro Device Selection

Based on this evaluation…

This individual is a recommended for myoelectric *elbow* restoration *with*:

☐ Multi-articulating, friction wrist-joint model *without motorized grasp* (MyoPro Motion W)

OR

☐ Motorized 3-jaw chuck grasp model + multi-articulating wrist (MyoPro Motion G)

OR

☐ **Fixed-wrist model only** (MyoPro Motion E), because candidate is incapable of *passive wrist pronation/supination*, or CPO plans to modify distal end with customized terminal component.

If this individual does not qualify for any MyoPro device, do you recommend re-evaluation after a period of time during which the candidate will complete additional therapy or other intervention(s) to resolve the reasons for disqualification?

☐ No ☐ Yes, when to re-evaluate?:_____

Please write below, or attach, any additional comments or recommendations you have regarding the candidacy of this individual: