State of Illinois
Department of Healthcare and Family Services

Prosthetic Questionnaire

Customer Name: _____ DOB: _____ RIN: _____

Height: _____ Weight: _____

To Be Completed by Physician

Date(s) of amputation: _____ Level of amputation: _____

Select One: Left ☐ Right ☐ Bilateral ☐

Circumstances leading to amputation:

Please provide medical/surgical history and CURRENT status of comorbid conditions:

All descriptions of function, limb descriptions and measurements, must be within the last three months.

Describe the residual limb and healing status with measurements (may attach additional documentation for measurements):

Equivalent Current Functional Capacity:

☐ K1 - Has the ability or potential to use prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.

☐ K2 - Has the ability or potential for ambulation with the ability to traverse low-level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.

☐ K3 - Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity throughout the day that demands prosthetic utilization beyond simple locomotion.

☐ K4 - Has the ability or potential potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

Current Functional Status (attach recent OT or PT therapy notes, or, narrative functional assessment by a physician), including; gait, stairs, assistive device, ADLs:

Practitioner Name: _____

Practitioner Signature: _____ Date: _____

Office Phone: _____ Fax: _____ NPI: _____

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To Be Completed by Prosthetist

1. Date the current prosthesis was received by the customer: _____
2. Explain why the existing device no longer meets the customer's current needs:

3. Please indicate modifications and adjustments (and dates) made by prosthetist for continued use:

4. Please provide evidence that this prosthesis is irreparable or that it cannot be repaired or modified to meet the needs of the customer:

Attach the questionnaire, a completed HFS 1409, Prior Approval Request Form, L code justification, and the practitioner order for items requested.

Prosthetist Name: _____

Prosthetist Signature: _____ Date: _____

Office Phone: _____ Fax: _____