

### Gait Trainers

**Prior authorization may be considered for the gait trainer with the following documentation:**

Clients HT: \_\_\_\_\_ WT: \_\_\_\_\_ DX: \_\_\_\_\_

Diagnosis relevant to the requested equipment, including functional level and ambulatory potential: \_\_\_\_\_  
\_\_\_\_\_

Anticipated benefits of the equipment: \_\_\_\_\_  
\_\_\_\_\_

Frequency and amount of time of a standing program: \_\_\_\_\_  
\_\_\_\_\_

Anticipated length of time the client will require this equipment: \_\_\_\_\_  
\_\_\_\_\_

Anticipated changes in the clients needs, anticipated modifications, or accessory needs, and growth potential: \_\_\_\_\_  
\_\_\_\_\_

Documentation by the physician familiar with the client that the client has ambulatory potential and will benefit from a gait training program: \_\_\_\_\_  
\_\_\_\_\_

Ambulatory Potential: Expected within 1 year \_\_\_\_ Not Expected \_\_\_\_  
Expected in future within \_\_\_\_ years

Will client benefit from a gait training program: YES \_\_\_\_ NO \_\_\_\_

Therapist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_