AMPUTEE REHABILITATION SERVICE: ASSESSMENT FORM

NAME: .................................................................
DOB: .......................  UNIT NO: ......................
NHS NUMBER: ..........................................................
ADDRESS: ..................................................................
...........................................................................
...........................................................................
TEL NO: .................................................................

PREferred NAME:.................................
CONSULTANT: .................................
GP: .........................................................
ADDRESS: ..........................................................
...........................................................................
TEL NO: .................................................................
DATE OF ASSESSMENT: ....................

CONTACT DETAILS
NEXT OF KIN:  
OTHERS: 

AMPUTATION DETAILS:

<table>
<thead>
<tr>
<th>Right</th>
<th>Hospital Ward</th>
<th>Date of Surgery</th>
<th>Left</th>
<th>Hospital Ward</th>
<th>Date of Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfemoral</td>
<td></td>
<td></td>
<td>Transfemoral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transtibial</td>
<td></td>
<td></td>
<td>Transtibial</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HISTORY OF PRESENT CONDITION

PREVIOUS MEDICAL HISTORY:

CVA  CARDIAC  DIABETES

Respiratory conditions

Known Allergies  Latex

Other

Information Obtained From: .......................................................  Date: ...........................................
Signature: .........................  Print Name: .................................  Physiotherapist

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CONTINENCE
Bladder: frequency urgency nocturnal frequency (*Falls risk)
Bowels:

SENSORY
SIGHT: Difficulty seeing across the room Difficulty reading
Wears glasses: Bifocals/Varifocals (*Falls risk)
Sight test last 12 months Yes / No
Hearing: use of hearing aid(s)
Alcohol: *Falls risk Smoking habit:
Emotional state: Social / Leisure activities:
“RDAC Empowering people” Leaflet given
Occupation:

SOCIAL HISTORY
House Own Part of a House Rented Bungalow Council Flat With Spouse Sheltered With family Other Alone

ACCESS (indicate number of steps/ramp/rails etc): *Falls risk: has environment been assessed
Front Rear/Side Stairs Stair Lift Through floor lift

Information Obtained From: .................................................. Date: ........................................
Signature: ........................................ Print Name: ........................................ Physiotherapist
AMENITIES
Bathroom / Shower  Toilet

AIDS CURRENTLY PROVIDED
Bath/shower  Toilet
Other

PRE-AMPUTATION FUNCTIONAL INDEPENDENCE
Dressing  Toilet  Bath
Shopping  Cooking

PRE-AMPUTATION MOBILITY / DISTANCE – See Locomotor Index
Outdoors:
Limited by:  Pain (R) Leg  (L) Leg  Other
Aids used:
Wheelchair  Motorised Scooter

Indoors:
Limited by:  Pain (R) Leg  (L) Leg  Other
Aids used:
Wheelchair:  self propelled  Electric: indoor  outdoor

CURRENT FUNCTIONAL MOBILITY AND TRANSFERS
Wheelchair mobility
Bed mobility
Dressing
Gait (if applicable)
Transfers
PHYSICAL ASSESSMENT

Record on body map sites of pain, altered sensation, pressure areas.

RESIDUUM:
- Wound

Pain
- Oedema
- Phantom sensations
  *Falls risk

ROM/POWER

LEGS:
- Affected
- Unaffected

HIP

KNEE

ANKLE

SKIN CONDITION *¹

SENSATION / PROPRIOCEPTION

PRESSURE AREAS

*¹ SKIN include: temp, colour, hair growth, nail condition, oedema, presence of lesions

Information Obtained From: .......................................................... Date: ........................................
Signature: ............................... Print Name: ........................................... Physiotherapist
NAME: ..............................................................
DOB: ...............................................................
UNIT NO: ..........................................................
NHS NO: ..........................................................

ARMS: Left Right

ROM/POWER

SHOULDER

ELBOW

WRIST

HAND / GRIP

SKIN CONDITION *

SENSATION / PROPRIOCEPTION

* SKIN include: temp, colour, hair growth, nail condition, oedema, presence of lesions

TRUNK: Posture: in sitting in standing with prosthesis

Balance: in sitting in standing with/without prosthesis

* Falls risk:

BACK: Range of Movement Pain

NECK: Range of Movement Pain

Dizziness * Falls risk

PULSES

RIGHT LEFT

Femoral Femoral

Popliteal Popliteal

Posterior Tibial Posterior Tibial

Dorsalis Pedis Dorsalis Pedis

CARDIO RESPIRATORY STATUS

Information Obtained From: .......................................................... Date: ........................................
Signature: ............................ Print Name: ............................................ Physiotherapist
### FALLS HISTORY

<table>
<thead>
<tr>
<th>Number of falls in last 6 months</th>
<th>Any injuries / fractures as a result of falls</th>
<th>A &amp; E attendance</th>
<th>Hospital admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of previous falls</td>
<td>Time: am / pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity at time of fall</td>
<td>Location: Indoor / Outdoor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Were you able to get up from floor: Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of latest falls</td>
<td>Time: am / pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity at time of fall</td>
<td>Location: Indoor / Outdoor</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Were you able to get up from floor: Yes / No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Were you able to seek help? Yes / No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Information Obtained From: ............................................. Date: ................................ Signature: ................................ Print Name: ................................................ Physiotherapist

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### FUNCTIONAL STATUS AT DISCHARGE FROM HOSPITAL

**Wheelchair mobility**

**Manipulation of wheelchair components:**
- Foot rest
- Support board
- Arm rests
- Brakes

**Transfer from wheelchair to / from:**
- Bed
- Toilet / Commode
- Arm chair
- Car

**Bed mobility:**
- Rolling
- Sitting up
- Bridging

**Hop with Aid (if appropriate)**
- Step
- Stairs

**Get up off floor**
- Other

Information Obtained From: ............................................. Date: ................................ Signature: ................................ Print Name: ................................................ Physiotherapist

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ARTIFICIAL LIMB

Type: __________________________

Prosthetist: _____________________

Date received: __________________

Contractor: _____________________

Information Obtained From: ______________ Date: ______________

Signature: _____________________ Print Name: _____________________

Physiotherapist

FUNCTIONAL STATUS AT DISCHARGE FROM OUT-PATIENT PHYSIOTHERAPY SERVICE

Progress towards achievement of patients own long term expectations / goals (see separate document)

Don / Doff Prosthesis

Dress

Mobility Indoors

Mobility Outdoors

Toilet

Bath

Step

Stairs

Slope

Rough ground

In / out car

Public transport

Get up off floor with prosthesis

without prosthesis

Other

DATE OF HOME VISIT (if appropriate):

DATE OF DISCHARGE FROM HOSPITAL:

DATE OF DISCHARGE FROM OUTPATIENT PHYSIOTHERAPY SERVICE:

DATE OF DISCHARGE SUMMARY SENT TO GP/CONSULTANT:

Information Obtained From: ____________________________ Date: ______________

Signature: ______________________ Print Name: __________________________

Physiotherapist
NAME: ……………………………………………………
DOB: ……………………………………………………
UNIT NO: …………………………………………………
NHS NO: …………………………………………………

**Physiotherapy Service, Amputee Rehabilitation Service Assessment form 2009**

**LOCOMOTOR INDEX**

<table>
<thead>
<tr>
<th>6 months pre-amputation</th>
<th>Initial assessment post delivery</th>
</tr>
</thead>
</table>

**DATE:**

1. Get up from a chair
2. Pick up an object from the floor when standing
3. Get up from the floor
4. Walk indoors
5. Walk outside on even ground
6. Walk outside on uneven ground (eg grass, gravel, slope)
7. Walk outside in bad weather (eg rain, snow)
8. Go up the stairs with a handrail
9. Go down the stairs with a handrail
10. Step up a kerb
11. Step down a kerb
12. Go up a few steps without a handrail
13. Go down a few steps without a handrail
14. Walk while carrying an object

**TOTAL SCORE:**

**PRINT NAME & SIGNATURE OF ASSESSOR:**

**DESIGNATION OF ASSESSOR:**

**KEY:**
1 = No  2 = Yes, if someone helps  3 = Yes, if someone is near  4 = Yes, alone

<table>
<thead>
<tr>
<th>1st Early Walking Aid</th>
<th>Last Early Walking Aid</th>
<th>1st Prosthesis</th>
<th>2 weeks post delivery</th>
<th>Discharge</th>
</tr>
</thead>
</table>

**DATE:**

Timed 10 metre walk
Timed ‘L’ Get up and Go

**PRINT NAME & SIGNATURE OF ASSESSOR**

**DESIGNATION OF ASSESSOR**