

GENERAL

Joint History: _____

Affected Joints: Right Knee Left Knee Right Hip Left Hip Right Ankle Left Ankle
 Right Hand Left Hand Right Foot Left Foot Other _____

BP: _____ **Heart Rate:** _____ **Height:** _____ **Weight:** _____ **BMI:** _____

Weight / Nutrition: _____

Current Medications (including herbals, vitamins and over the counter): See attached list if available

Medication allergies or reactions:

<u>Allergy</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

Have you seen a Rheumatologist or a Surgeon already? Yes No _____

Has your family doctor ordered referrals / tests? Yes No _____

Clinically relevant medical conditions:

Cardiovascular Musculoskeletal Neurological Renal Elimination
 Respiratory Gastrointestinal Mental Health Endocrine Other: _____

Comments: _____

Smoker (tobacco) If yes, how much? _____

Alcohol If yes, type and how much? _____

Other substance use If yes, type and how much? _____

Clinician Signoff: _____



PAIN

How well is client managing pain (0-10)?

Affected Areas: _____

Onset: _____

Characteristics: _____

Triggers: _____

FUNCTION

Social History/Home Environment: _____

Self Care/ADL: _____

Mobility: _____

Work/Volunteer: _____

Leisure/Sport: _____

Clinician Signoff: _____

FUNCTION

GAIT

Trendelenburg sign R: Positive Negative L: Positive Negative **Walking Speed Score** _____

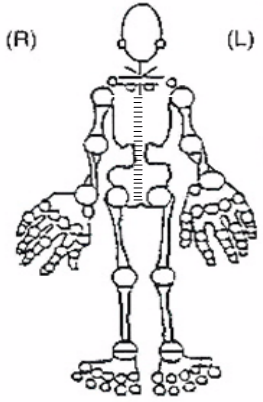
BALANCE

Berg: _____ TUG: _____ Falls History? Yes No If yes, when? _____

OBSERVATIONS

Swelling: _____

Sensation: _____

	RANGE OF MOTION/STRENGTH:	RIGHT		LEFT	
		PROM	Strength	PROM	Strength
	Hip	Flexion (110-120)			
		Extension (10-15)			
		Abduction (30-50)			
		Adduction (30)			
		External rotation (40-60)			
		Internal rotation (30-40)			
Knee	Flexion (135)				
	Extension (0)				
Foot	Dorsi-flexion (20)				
	Plantar-flexion (50)				

Leg Length: R: _____ cm L: _____ cm **Comments:** _____

Muscle Length: _____

Knee Alignment: R: Varus Valgus _____ Normal L: Varus Valgus _____ Normal

Ligament Stability: R: Stable Unstable L: Stable Unstable Comment: _____

Special Tests _____

Clinician Signoff: _____



ASSESSMENT SUMMARY

Summary of X-Ray Findings: _____

Impressions:

Surgical Consult Status at Time of Assessment:

No Consult Already Been Referred Consult Complete Surgeon: _____

Patient Care Path:

Conservative OA Conservative Non-OA Surgical TJR Surgical Other _____

OASIS SURGICAL REFERRAL

Consultation Surgeon: _____

OASIS Assessment of Surgical Need: Potential Probable Highly Probability

Consult Priority: Elective Urgent Emergent

Patient Indicates: Interested in Surgery Not Interested in Surgery Undecided

Surgical Joint: _____

Comments:

FOLLOW-UP PLAN

Follow-up Recommended (less than 1 year): Telephone Appointment Date within _____

Follow-up Care Plan:

Full Reassessment Recommended (1 year or greater): Date within _____

Clinician Signoff: _____