McLaren Business Products

McLaren Print System Order

Order No: 59578
Order Date: 2021-01-12
User: Melissa Jordan
Phone: 810-342-2642

Ship Location: McLaren Flint - 1 Central Quality Management Attn: Melissa
401 Ballenger Highway
Flint, MI 48532
Forms
Quantity: 100
Paragon Dept No: 91650
Dept Name: Quality Managment
Company Number: 60

Order Total Price: 16.76

Item Number: M-34128
Item Description: Appendix U6_Form Cerv 1 and 2 Year Postop Questionnaire
Revision Date: 2020
Print: 2 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: Staple (Upper Left)
Drill: None
Misc Info: ds; black & white; 4 pages; bond

Spec Info:

MSSIC Data Registry
Cervical 1 and 2 Year PostOperative
Patient Questionnaire

Patient Name: _____ MRN: _____ Registry ID: _____

Date of Questionnaire: _____

We ask that you please complete this form as fully and accurately as possible. Some questions may be difficult, but we ask that you answer them to the best of your ability. Please be sure to follow the directions in each section. Clearly print responses and mark boxes where needed.

Thank you for your time filling out this questionnaire, your answers will help us to provide the best possible spine care.

Follow-Up Questionnaire Time Interval – How long has it been since your last surgery?

- ☐ 1 Year
- ☐ 2 Years

Which answer best represents your level of satisfaction with your surgical outcome?

- ☐ Surgery met my expectations
- ☐ I did not improve as much as I had hoped but I would undergo the same operation for the same results
- ☐ Surgery helped but I would not undergo the same operation for the same results
- ☐ I am the same or worse as compared to before the surgery

Neck & Arm Pain Scale

Please describe your neck and arm pain when off your pain medication. Please rate your neck pain and arm pain on a scale of 0 to 10, where zero (0) would mean "no pain" and a ten (10) would mean "worst pain imaginable."

For example, describe your pain when you are off your medication, after your pain medication has worn off, when you are due to take your next pill, that is please describe how your pain would feel if you were not on pain medication.

Please rate your neck pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

Now, please rate your arm pain on a scale of 0 to 10 over the past 7 days (0 through 10): _____

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By marking one box in each group below, please indicate which statements best describe your own health state today.

Mobility

- ☐ I have no problems in walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed

Self-Care

- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

Pain/Discomfort

- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

Anxiety/Depression

- ☐ I am not anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am extremely anxious or depressed

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