McLaren FLINT

TOTAL JOINT REPLACEMENT THERAPY EVALUATION

DATE:	Age:	Sex:	Diagnosis:

Medical History: _____

_____

History with Assistive Devices: _____ no _____ yes, when_____

_____ crutches _____ walker _____ cane _____ tub seat _____ grab bars, where _____

_____ raised toilet seat _____ other _____

Discharge Destination: _____

Stairs #into home _____ #inside home _____ Bedroom: ____ first level ____ second level

Railing (s): ___ right ___ left ___ right ___ left Bathroom: ____ first level ___ tub ___ shower

____ second level ___ tub ___ shower

Caregiver: _____

PRE-OPERATIVE ASSESSMENT

Ambulation Status: _____

Transfer Status:

Sit to Stand: ___ Independent ___ Assistance Needed

Toilet: ___ Independent ___ Assistance Needed

Tub/Shower: ___ Independent ___ Assistance Needed

Lower Body ADL Status:

Bathing: ___ Independent ___ Assistance Needed

Dressing: ___ Independent ___ Assistance Needed

Mentation: ___ Alert and oriented x_____ . Able to follow instructions ___ yes ___ no

Vision: ___ WFL Wears Glasses/lens ___ yes ___ no ___ Decreased or use of adapted equipment

Range of Motion: (circle extremity tested)

Right Upper Extremity: ___ Functional ___ Non-functional

Left Upper Extremity: ___ Functional ___ Non-functional

Right Lower Extremity: ___ Functional ___ Non-functional

Left Lower Extremity: ___ Functional ___ Non-functional

Specific Measurements (Active/Passive)

Right: _____ sitting _____ supine _____

Left: _____ sitting _____ supine _____

Gross Strength: (circle extremity tested)

Right Upper Extremity: ___ Functional ___ Non-functional

Left Upper Extremity: ___ Functional ___ Non-functional

Right Lower Extremity: ___ Functional ___ Non-functional

Left Lower Extremity: ___ Functional ___ Non-functional

Comments: _____

Pain Scale: During activity, on a subjective pain scale of 0 to 10, 0 being no pain and 10 being the most severe, patient reports a level of _____ pre-operatively.

Treatment: In this session, patient will be instructed how to:

_____ Ambulate with walker _____ feet Independently Standby Assistance and _____ (weight bearing status).

_____ Negotiate stairs with waker with _____ assistance.

_____ Perform the following exercises in therapy:

_____ ankle pumps _____ reps

_____ quad sets _____ reps

_____ glut sets _____ reps

_____ The patient will verbally agree to perform home exercise program as designed by therapist.

_____ Pre- and post-operative goals will be discussed with patient and/or caregiver.

_____ The patient will perform BADLs using approprate adaptive equipment with set-up assistance

_____ The patient demonstrates knowlegde of hip precautions (THR only)

Pre-Operative Assessment is continued on the back of this sheet.

Post-Operative Assessment is located on the back of this sheet.

PT.

MR.#/RM.

DR.

Recommendations:

_____ Patient has own assistive devices. _____

_____ Equipment recommened:

_____ walker _____ tub seat _____ raised toilet seat _____ raised toilet seat with handles

_____toilet handrails _____ grab bar

_____ ADL equipment _____ tub / shower grab bars _____ shower hose _____ ortho joint kit

Equipment company: _____ McLaren Home Medical Other:_____

Preference for Outpatient Therapy (PRN): _____

Comments: _____

Physical Therapist: _____ Date: _____

Occupational Therapist: _____ Date: _____

POST-OPERATIVE ASSESSMENT:

Weight-bearing status: _____

Neurovascular Signs:

Sensation: _____ intact _____ impaired

Skin Color: _____ Skin Temperature: _____

Comments: _____

Range of Motion: (circle extremity tested)

Right Upper Extremity: _____ Functional _____ Non-functional Right Lower Extremity: _____ Functional _____ Non-functional

Left Upper Extremity: _____ Functional _____ Non-functional Left Lower Extremity: _____ Functional _____ Non-functional

Gross Strength: (circle extremity tested)

Right Upper Extremity: _____ Functional _____ Non-functional Right Lower Extremity: _____ Functional _____ Non-functional

Left Upper Extremity: _____ Functional _____ Non-functional Left Lower Extremity: _____ Functional _____ Non-functional

Comments:_____

_____

Mentation: _____ Alert and oriented x _____. Able to follow instructions. _____ yes _____ no

Post-operative Treatment Goals: (By discharge from inpatient therapy)

_____ _____ assist on levels with _____ x _____ feet.

_____ _____ assist on stairs with _____

_____ _____ assist with transfers.

_____ _____ assist with home exercise program

_____ _____ assist using adaptive equipment for BADL's

_____ 10˚ - 70˚ degrees knee ROM (TKR's).

_____ Able to demonstrate precautions for total joint replacement.

_____ Other: _____

_____

Treatment:

_____ Bed mobility and transfer training.

_____ Further instruction in ambulation on level surfaces

_____ Further instruction on stairs.

_____ Stretching and strengthening exercises.

_____ Provide Home Exercise Program.

_____ Schedule outpatient therapy PRN.

_____ Educate on safety issues/precautions.

_____ Discontinue inpatient Physical Therapy. Patient is independent in mobility, uses _____ and equipment has been supplied/recommended.

_____ Discontinue inpatient Occupational Therapy (THR's). Pt is independent with BADL's utilizing appropriate adaptive equipment.

Physical Therapist: _____ Date: _____

Occupational Therapist: _____ Date: _____

TOTAL JOINT REPLACEMENT THERAPY EVALUATION

PT.

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