PHYSIOTHERAPY DEPARTMENT

PHYSIOTHERAPY AMPUTEE ASSESSMENT

Inpatient/Outpatient (*please circle)*
Date of Assessment: ___/___/___
Medicare Number: _____
CentreLink/Pensioner Card No. _____
DVA Nx File No. _____

Attach Patient's Identification Label
MRN:
Name:
Address:

DOB:

SUBJECT EXAMINATION

1. **HISTORY OF PRESENT CASE**	
▪ Date of Amputation	
▪ Level and side of Amputation	
▪ Place of Amputation Rehabilitation Specialist • Surgeon • G.P./LMO	
▪ Reason for Amputation (*please circle)*	Trauma/ PVD/ DM/ Infection/ Cancer/ Other
▪ Rigid Dressing (*also see later)*	
▪ Hospital Discharge Date and location/destination	
▪ Date of Last Podiatry Review for intact limb	
HPI AND POST OP COURSE:	

2. **PAST MEDICAL HISTORY**	3. **MEDICATIONS**

4. **PRE OPERATIVE CONDITION**	
▪ Exercise tolerance ❑ Household ❑ Active/outdoor ❑ Community	
▪ Use of walking aids	
▪ Time since able to walk	
▪ History of falls in last 12 months	
▪ Smoking history/ETOH/IV drug use	

5. **SOCIAL HISTORY**	
▪ Work /Previous Occupation	
▪ Home Environment/House Access	
▪ Lifestyle/Hobbies	
▪ Carer/Family/Social Support/Services	
6a. **PAIN (Stump/Phantom)**	6b. **PHANTOM SENSATION**
0 _____ 10 VAS	Description:
Location:	Location:
Frequency/Duration:	Frequency/Duration:
7a. **PATIENT'S SHORT TERM GOALS** *(include timeframes)*	7b. **PATIENT'S LONG TERM GOALS** *(include timeframes)*
8. **FEELINGS TOWARDS AMPUTATION**	
9. **OTHER RELEVANT INFORMATION** (eg: LBP, Rigid Dressing, Details, Precautions)	

OBJECTIVE EXAMINATION

10. **MENTAL STATUS/MOTIVATION/MMSE /30**	
11. **PATIENT'S WEIGHT**	
12. **STUMP OEDEMA MANAGEMENT**	
13. **STUMP CONDITION:**	14. **DIAGRAM OF STUMP/ STUMP MEASUREMENT**
Scar Mobility/Suture Line	
Skin Condition	
Sensitivity/Tolerance/Pain	
Sensation	
15. **CONDITION OF INTACT LIMB**	

16. **MUSCULO-SKELETAL SYSTEM**				
Upper Limbs				
Lower Limbs	**Range/Muscle Length**		**Strength**	
	Left	**Right**	**Left**	**Right**
HIP: Flexion				
Extension				
Abduction				
Adduction				
Internal Rotation				
External Rotation				
KNEE: Flexion				
Extension				
ANKLE: Dorsi-Flexion				
Plantar-Flexion				

17. **FUNCTION (with/without prosthesis, including any aids)**	
▪ Wheelchair	
▪ Bed Mobility	
▪ Transfers	
▪ Sit to Stand	
▪ Standing	
▪ Mobility	
▪ Up from Floor	
▪ Timed 10m Walk	
▪ Stairs	
▪ Amp Pro/Amp No Pro Score	
▪ Other Functional Outcome Measures	

ASSESSMENT AND PLAN

18. **MAJOR PROBLEMS**	
19. **TREATMENT PLAN**	
20a. **SHORT TERM GOALS**	20b. **TIME FRAME**
21. **LONG TERM AIM**	21b. **TIME FRAME**

22. **CIRCUMFERENTIAL STUMP MEASURES**

DATE		**Initial**										
Suture Line												
5 cm	2 cm											
10 cm	4 cm											
15 cm	6 cm											
20 cm	8 cm											
25 cm	10 cm											

PHYSIOTHERAPY ASSESSMENT FOR THE PROSTHETIC USER				
	DATE OF 1ST TEMPORARY PROSTHESIS: _____ **DATE OF 2ND TEMPORARY PROSTHESIS: _____** **DATE OF 3RD TEMPORARY PROSTHESIS: _____**			**DATE OF DEFINITIVE PROSTHESIS: _____**
Date				
Type of Prosthesis				
Don/Doff				
Walking Aids				
TUG Test				
Velocity – 10m walk test				
2 minute walk test				
Stand and Reach test				
Amount of Walking per Day				
Length of Time Wearing Prosthesis per Day				