Ideal HealthCare
A MOBILITY CLINIC COMPANY

Lower Extremity Prosthetic Evaluation Form

Name: _____ Date: _____

D.O.B.: _____ Practitioner: _____

Height: _____ Weight: _____ Sex: □ M □ F Assistant: _____

Amputation Date: _____ Physician: _____

Skin Tone: _____ Secondary: _____

Involvement: □ Left □ Right □ Bilateral Therapist: _____

Location of Patient Evaluation	□ Office □ Nursing Home	□ Home □ Rehab. Hospital	□ Skilled Nurse Facility □ Outpatient Facility	□ Acute Hospital
Physical Therapy	□ Ongoing	□ Needed	C Patient would like a referral	□ N/A
Living Status	□ Alone	□ Home w/ Assistant	□ LTCF	□ _____
Living Conditions	□ Level Surfaces	□ Level with steps	□ Uneven Surfaces	□ Uneven w/Steps
Patient's Vocation		Seated _____%	Standing _____%	Variable Cadence _____%
Recreation	□ Bicycling □ Swimming □ Baseball	□ Jogging □ _____ □ _____	Specialty Prosthesis Needed □ Yes □ No Type: _____	
Current Medication				
Cognitive abilities	□ Normal □ Impaired	Explain:		
Current Assistive Devices Used	**Devices** □ Handrails Present (home) □ Ramps present (home) □ Walker □ Crutch □ Cane □ Wheelchair	**Type** _____ _____ _____ _____ _____ _____		
Reason for Amputation	□ Trauma □ Vascular □ Heart	□ Diabetic □ Congenital □ _____	□ Other Medical Conditions:	
Desire to Walk or Run (Potential)			Pre-Amputation Ambulatory Status:	

Prosthesis Longevity and Patient Wearing Schedule	Number of years patient has worn a prosthesis: _____ year(s) Age of current prosthesis: _____ month(s) or _____ year(s)	
Heart Health		
Skin Condition	Invaginated Scars	Adherent Scar Tissue
Upper Extremity Involvement	ROM at Shoulders	Hand Dexterity
Vision		
Prosthetic History and/or Current Problems to Resolve		

Additional Information

Goals & Why Goals Cannot Be Accomplished				
Household Chores to be Completed				
Work Environment	□ Small Spaces	□Wet Environment	□ Obstacles	□ Other: _____
Environmental Barriers Encountered	□ Ramps/Slopes □ Grass	□ Stairs □ Gravel	□ Curbs □ Other: _____	
Transportation Utilized	□ Train Stations	□ Airports	□ Buses	□ Other: _____

Strength and Range of Motion Measurements

(Test both Sides) Amputation is on: □ **Right** □ **Left** □ **Bilateral**

Contractures	R	✓	R	✓	Degree	L	✓	L	✓	Degree
Ankle	Y		N			Y		N		
Hip	Y		N			Y		N		
Knee	Y		N			Y		N		

ICD-9	✓	Level	ICD-9	✓	Level
ICD.9 895.0		Toe	ICD.9 897.2		Transfemoral
ICD.9 896.0		Partial Foot	ICD.9 897.4		Hip Disarticulation
ICD.9 896.0		Ankle Disarticulation	ICD.9 897.4		Pelvic Disarticulation
ICD.9 897.0		Transtibial	ICD.9 897.4		Not Otherwise Specified
ICD.9 897.4		Knee Disarticulation	ICD.9 897.6		Bilateral Any Level

Strength	Nothing				Trace				Poor				Fair				Good				Normal			
Ankle		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓
Dorsiflexion	R		L		R		L		R		L		R		L		R		L		R		L	
Plantar Flexion	R		L		R		L		R		L		R		L		R		L		R		L	
Inversion	R		L		R		L		R		L		R		L		R		L		R		L	
Eversion	R		L		R		L		R		L		R		L		R		L		R		L	
Knee		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓
Flexion	R		L		R		L		R		L		R		L		R		L		R		L	
Extension	R		L		R		L		R		L		R		L		R		L		R		L	
Hip		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓		✓
Flexion	R		L		R		L		R		L		R		L		R		L		R		L	
Extension	R		L		R		L		R		L		R		L		R		L		R		L	
Abduction	R		L		R		L		R		L		R		L		R		L		R		L	
Adduction	R		L		R		L		R		L		R		L		R		L		R		L	
Internal Rot	R		L		R		L		R		L		R		L		R		L		R		L	
External Rot	R		L		R		L		R		L		R		L		R		L		R		L	

Residual Limb Health

Length Overall	_____ □ inches □ cm
Tissue Consistency	□ Soft □ Medium □ Firm

	Where
□ Distal Loading	_____
□ Bulbous	_____
□ Discoloration	_____
□ Scarring	_____
□ Delayed Healing	_____
□ Drainage	_____
□ Neuroma	_____
□ Bony Prominences	_____
□ Adhesions	_____
□ Phantom Pain/ Sensation	_____
□ M/L Instability	_____

Additional Comments:

Functional Level Assessment

□ 0	No Ability or potential to ambulate or transfer
□ 1	Ability or potential to transfer or ambulate on level surfaces at fixed cadence
□ 2	Ability or potential for ambulation with ability to traverse low level barriers
□ 3	Ability or potential to ambulate with variable cadence
□ 4	Ability or potential to ambulate which exceeds basic ambulation skills

CURRENT Functional Level – K ____ **EXPECTED Functional Level – K ___**

Type of Service

New Patient	□ Yes	□ No		
Replacement	□ Entire	□ Socket Only	□ Components _____	
Replacement Due To:	□ Change in Residual Limb □ Weight Gain or Loss	□ Functional Activity Level □ Irreparable Damage	□ Wear and Tear □ Other: _____	
Type of Prosthesis	□ IPOP/EPOP □ Prep/Temp	□ Definitive □ Sport	□ Cosmetic □ Endoskeletal	□ Exoskeletal
Other Details:				

Plan

Plan to cast/measure for the prosthesis: **When the residual limb is:**	□ **This Visit** □ **Ready**	□ **Next Visit** □ **Other _____**
A test/diagnostic procedure (if necessary) will be scheduled on the following visit _____		
Dynamic alignment will be scheduled after:	□ **Casting**	□ **Test Socket**
	□ **Other _____**	
Final Delivery will be scheduled in approximately _____ days.		

Practitioner Signature _____ Date _____

Patient Signature _____ Date _____