

KNEE REPLACEMENT PRE-OP

Name:		PARIS ID:
DOB:	Age:	PHN:
Gender:		Phone:
Home Address:		

Assessment Start Date:

Assessment End Date:

Carried Out By:

Unregistered Contacts

Contact Name	Primary Number	Alternate Number	Association	Comments
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Assessment

Anticipated Date of Surgery:

☐ Right ☐ Left

☐ Total Knee ☐ Uni-compartmental knee

Pain Assessment 0-10

at rest:

with activity:

Nocturnal:

Operative Knee

ROM (degrees)

Flex (135):

Ext (0):

Strength (Oxford Scale 1-5)

Quads:

Hams:

Ambulation

Aids:

Distance:

Stairs:

Railing up on ☐ Right ☐ Left

☐ Elevators

Oxford Hip Score (out of 60):

Leg Length Discrepancy:

TEDS stockings size:

Post-Op swelling management:

Home Environment

ADL/IADLs setup

Toileting ☐ Independent ☐ Needs Assistance

Bathing ☐ Independent ☐ Needs Assistance

Family support available during day

☐ Yes ☐ No Other support available:

Comments:

Cognitive Status and Safety Awareness:

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Patient Understands

- ☐ stair management ☐ crutch walking ☐ exercise regimen
☐ safe car transfers

Meal Management:

Shopping / Household tasks:

Transportation - current

- ☐ Driving ☐ Is driven ☐ Bus
☐ Taxi ☐ HandyDart

Conditions that may affect post-operative rehabilitation:

Equipment

Equipment - Entry	
Equipment	
<u>Recorded By</u>	<u>Date Recorded</u>
<u>Team</u>	
Equip Type	Repair Co.
Equip Item	Vendor
Funding Source	
If Other, Specify	
ID Funding Source	Urgency
Serial No.	Purchase / Loan / Rent
Replacement Value	GF Strong ATSS Number
Equip Mods.	
Date Requested	Period Of Loan (Weeks)
Date Received	No longer Applicable <input type="checkbox"/>
Review Usage On	Due Return Date
Client/Caregiver Competent with Equipment <input type="checkbox"/>	Date Equip Returned
Comments	

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Recommendations / Resources

Needs

Need

Post to C/P

Processed

Comments

Casenote

Note: Once downtime information from this form has been entered in PARIS, shred this working sheet.

----- End of Report -----