

Pixalere Basic Upper Limb Assessment Worksheet

Date	Name	PixID#
Parameters	Right Upper Limb	Left Upper Limb
Missing Limbs or Digits	<input type="checkbox"/> Arm above elbow <input type="checkbox"/> Arm below elbow <input type="checkbox"/> Hand partial <input type="checkbox"/> Hand all <input type="checkbox"/> Thumb <input type="checkbox"/> Second finger <input type="checkbox"/> Third finger <input type="checkbox"/> Fourth finger <input type="checkbox"/> Fifth finger <input type="checkbox"/> Not applicable	<input type="checkbox"/> Arm above elbow <input type="checkbox"/> Arm below elbow <input type="checkbox"/> Hand partial <input type="checkbox"/> Hand all <input type="checkbox"/> Thumb <input type="checkbox"/> Second finger <input type="checkbox"/> Third finger <input type="checkbox"/> Fourth finger <input type="checkbox"/> Fifth finger <input type="checkbox"/> Not applicable
Skin Colour	Arm: <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black	Arm: <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black
	Hand: <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black	Hand: <input type="checkbox"/> Pale <input type="checkbox"/> Flesh Tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/Purple <input type="checkbox"/> Black
	Fingers: <input type="checkbox"/> Pale <input type="checkbox"/> Flesh tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black	Fingers: <input type="checkbox"/> Pale <input type="checkbox"/> Flesh/tone <input type="checkbox"/> Red <input type="checkbox"/> Bluish/purple <input type="checkbox"/> Black
Skin Warmth	Lower Arm: <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot	Lower Arm: <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot
	Hand: <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot	Hand: <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot
	Fingers: <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot	Fingers: <input type="checkbox"/> Cold <input type="checkbox"/> Cool <input type="checkbox"/> Warm <input type="checkbox"/> Hot
Circulation Pulses by Palpation	Radial: <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable	Radial: <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable
	Brachial: <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable	Brachial: <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Non-palpable
Capillary Refill ≤3 sec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Capillary Refill ≥3 sec	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Parameter	Right Upper Limb	Left Upper Limb
Range of Motion	Elbow: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased	Elbow: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased
	Wrist: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased	Wrist: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased
	Thumb: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased	Thumb: <input type="checkbox"/> Normal <input type="checkbox"/> Decreased
Edema	Location	Location
	<input type="checkbox"/> Hand <input type="checkbox"/> Up to wrist <input type="checkbox"/> Up to elbow <input type="checkbox"/> Up to shoulder <input type="checkbox"/> No visible edema	<input type="checkbox"/> Hand <input type="checkbox"/> Up to wrist <input type="checkbox"/> Up to elbow <input type="checkbox"/> Up to shoulder <input type="checkbox"/> No visible edema
	Severity	Severity
	<input type="checkbox"/> Non-pitting <input type="checkbox"/> +1 Trace 2mm pitting <input type="checkbox"/> +2 Moderate 4mm pitting <input type="checkbox"/> +3 Deep 6mm pitting <input type="checkbox"/> +4 Very deep 8mm pitting <input type="checkbox"/> None noted	<input type="checkbox"/> Non-pitting <input type="checkbox"/> +1 Trace 2mm pitting <input type="checkbox"/> +2 Moderate 4mm pitting <input type="checkbox"/> +3 Deep 6mm pitting <input type="checkbox"/> +4 Very deep 8mm pitting <input type="checkbox"/> None noted
Circumference Measurements	Wrist : _____ cm Forearm: _____ cm	Wrist : _____ cm Forearm: _____ cm
Skin Appearance	<input type="checkbox"/> Dry/flaky <input type="checkbox"/> Itchy <input type="checkbox"/> Rash present <input type="checkbox"/> Fragile <input type="checkbox"/> Weepy <input type="checkbox"/> Hairless <input type="checkbox"/> Mottled <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Blister(s) present <input type="checkbox"/> Wound(s) present <input type="checkbox"/> None of the above	<input type="checkbox"/> Dry/flaky <input type="checkbox"/> Itchy <input type="checkbox"/> Rash present <input type="checkbox"/> Fragile <input type="checkbox"/> Weepy <input type="checkbox"/> Hairless <input type="checkbox"/> Mottled <input type="checkbox"/> Moist/waxy <input type="checkbox"/> Healed wound/scar <input type="checkbox"/> Blister(s) present <input type="checkbox"/> Wound(s) present <input type="checkbox"/> None of the above
Sensation	<input type="checkbox"/> Numbness <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Crawling <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> None of the above	<input type="checkbox"/> Numbness <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Crawling <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> None of the above
Pain	<input type="checkbox"/> Ache <input type="checkbox"/> Knife-like <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Nonverbal response <input type="checkbox"/> No pain	<input type="checkbox"/> Ache <input type="checkbox"/> Knife-like <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent <input type="checkbox"/> Nonverbal response <input type="checkbox"/> No pain
Comments		
Signature/Designation		