LOWER LIMB PROSTHETIC ASSESSMENT FORM

PATIENT INFORMATION

Name: ____________________ Evaluation Date: ____________________

D.O.B. ____________________ Practitioner: ____________________

Height: ____________________ Location of Patient Evaluation:

Weight: ____________________ ☐ Office ☐ Rehab Hospital ☐ Home

Sex: ☐ Male ☐ Female ☐ Skilled Nursing Facility ☐ Other

INITIAL OBSERVATION AND DIAGNOSIS

Amputation Date: ____________________ Referring Physician: ____________________

Amputation Side: ☐ Right ☐ Left ☐ Bilateral Date of Last Appointment: ____________________

ICD-9 Amputation Level

895.00 ☐ Toe	897.2 ☐ Trans-Femoral
896.00 ☐ Partial Foot	897.4 ☐ Hip Disarticulation
896.00 ☐ Ankle Disarticulation	897.4 ☐ Pelvic Disarticulation
897.00 ☐ Trans-Tibial	897.4 ☐ Not otherwise specified
897.20 ☐ Knee Disarticulation	897.6 ☐ Bilateral

Cause of Amputation

☐ Diabetes	☐ Motor Vehicle Accident	☐ Congenital
☐ Cardiovascular disease	☐ Peripheral vascular disease	☐ Other_______________
☐ Trauma		

TYPE OF SERVICE

New Patient/Service:	☐ Yes ☐ No		
Replacement:	☐ Entire ☐ Socket ☐ Components___________________________________		
Replacement Due To:	☐ Change in Residual Limb	☐ Functional Activity Level	☐ Wear & Tear
	☐ Weight Gain ☐ Loss	☐ Irreparable Damage	☐ Other:_____
Type of Prosthesis :	☐ IPOP	☐ Definitive	☐ Cosmetic
	☐ Prepatory	☐ Sport	☐ Endoskeletal
	☐ Exoskeletal	☐ Other:	
Details:			

MD Signature__________________

DAILY LIVING INFORMATION

Living Status:	☐ Alone in Home	☐ Home with Spouse/Family	☐ Long Term Care Facility	☐ Other
Living Conditions:	☐ Level Surfaces	☐ Level with Steps	☐ Uneven Surfaces	☐ Uneven with Steps
Patient's Vocation:		Seated____%	Standing____%	Variable Cadence ___%
Recreation:	☐ Bicycling	☐ Walking	☐ Sports	
	☐ Swimming	☐ Running	☐ Aerobics	
	☐ Shopping	☐ Domestic Chores	☐ Other ______________	
Physical Therapy:	☐ Does not go	☐ Ongoing	☐ Needed	☐ Pt would like a referral
Current Assistive	☐ Handrails Present (home)	☐ Walker	☐ Cane	
Devices Used:	☐ Ramps present (home)	☐ Crutch(s)	☐ Wheelchair	
Transportation Used:	☐ Drives own car	☐ Rides in Car	☐ Buses	☐ Trains ☐ Other
Desire to Ambulate:	Describe patients pre-amputation status: Is the patient motivated to ambulate: ☐ Yes ☐ No Describe the patients level of motivation to ambulate:			

PROSTHETIC HISTORY

☐ Patient has never worn a prosthesis
☐ Patient currently has a prosthesis

Number of years patient has worn a prosthesis:______year(s)

Age of current prosthesis:_________month(s) or ______years(s)

Daily wearing schedule: ______hours per day

Design and condition of current prosthesis: ☐ N/A

☐ Endoskeletal ☐ Exoskeletal

Socket: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Knee: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Suspension: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Foot/Ankle: ______________________________ ☐ *Acceptable as is*
☐ *Needs to be replaced because:*

Describe condition of current prosthesis: ______________________________

Does present prosthesis meet patient's current needs? (Function, safety, etc.) ☐ N/A ☐ Yes ☐ No
If no, explain: ______________________________

RESIDUAL LIMB HEALTH

Length Overall:	________ ☐ inches ☐ cm		
Tissue Consistency:	☐ Soft	☐ Medium	☐ Firm
Skin Condition:	☐ Normal	☐ Discoloration	☐ Open Wounds
Limb Shape:	☐ Normal	☐ Bulbous	☐ Conical
Contracture:	☐ Flexion	☐ Abduction	☐ None present
Other:	☐ Scars	☐ Bony Prominence	☐ Neuroma

Residual Limb Measurements: ________________Circumference ________________ Distance from IT

MD Signature________________

FUNCTIONAL LEVEL ASSESSMENT

K0 ☐ Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.

K1 ☐ **Household Ambulator:** Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at a fixed cadence.

K2 ☐ **Limited Community Ambulator:** Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces.

K3 ☐ **Unlimited Community Ambulator:** Has the ability or potential for ambulation with variable cadence. has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

K4 ☐ **Child, Active Adult or Athlete:** Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels.

Patients Existing Environmental Barriers	☐ Level Surfaces ☐ Level with steps ☐ Uneven surfaces ☐ Uneven with steps ☐ Ramps or Slopes ☐ Other
Gait Observations:	

PROSTHETIC RECOMMENDATIONS

Type of Prosthesis Required:	☐ Partial Foot ☐ Symes ☐ Below Knee ☐ Above Knee ☐ IPOP ☐ Preparatory/Temporary ☐ Definitive ☐ Other:

Foot: ______________________________

Rationale:
☐ Reduce Energy Consumption ☐ Increased Stability
☐ Walk on Uneven Terrain ☐ Variable Cadence

Comments: ______________________________

Knee: ______________________________

Rationale:
☐ Reduce Energy Consumption ☐ Increased Stability
☐ Variable Cadence ☐ Increased Comfort

Comments: ______________________________

Suspension: ______________________________

Rationale:
☐ Reduce Skin Abrasion ☐ Increased Stability
☐ Increased Prosthetic Control ☐ Increased Comfort

Comments: ______________________________

Socket: ______________________________

Rationale:
☐ Increase Control ☐ Increased Stability
☐ Increase Muscle Movement ☐ Increased Comfort

Comments: ______________________________

Liner/Insert: ______________________________

Rationale:
☐ Control Volume Change ☐ Increased Comfort
☐ Reduce Stress on Skin ☐ Improved Suspension

Comments: ______________________________

Protective Cover: ☐ Yes ☐ No ☐ Protect Internal Components ☐ Moisture Protection

Total Contact: ☐ Yes ☐ No ☐ Increased Venous return ☐ Increased Wt. Bearing Surface ☐ Increased Comfort

MD Signature________________

General Observations and Comments:

MD Signature___________________