Osseointegration Pre-Screening Questionnaire

Hello,

Thank you for your interest in our Osseointegration Program. We appreciate you taking the time to complete the following document. Any sections that are incomplete, may result is delayed processing time.

Personal Information

Name (First, MI, Last): ______________________________

Date of Birth: ______________________________

Address (Street): ______________________________

City: ______________ State ______________ Zip Code ______________

Email: ______________________________

Mobile Number: ______________ Home Number: ______________

Sex: ______________ Gender ______________

Preferred Language for Medical Terminology: ______________

Emergency Contact Name: ______________________________

Phone Number: ______________ Relationship: ______________

Are you currently employed? ☐Yes ☐No

If yes, what occupation? ______________________________

☐ Full Time ☐ Part Time ☐ Other: ______________

Living Arrangements

How many stairs are in your home?

Entrance: __________ Bedroom: __________ Bathroom: __________ Kitchen __________

Home Occupants?

☐ Alone ☐ Spouse/Partner ☐ Other: ______________

Are home occupants able to provide assistance? ☐ Yes ☐ No

Background

How did you hear about osseointegration? Choose an item.

Cause of Amputation? ______________________________

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Site of Amputation: ☐ Right ☐ Left ☐ Both

☐ Above Knee ☐ Below Knee ☐ Above Elbow ☐ Below Elbow

(If both sides, provide details as needed) : ____

Do you have any internal hardware in your residual limb? ☐ Yes ☐ No

Prosthesis Components: ____

Number of sockets used since initial amputation? ____

Any problems/ concerns with your sound limb? ☐ Yes ☐ No

Mobility Aids used in prosthesis? ____

How many hours per day do you wear prosthesis? ____

If using step-counter, how many steps per day with in your prosthesis? _________________________

How far can you comfortably walk **unaided?** ____

Are you currently undergoing physical therapy? ☐ Yes ☐ No

Health History

Height (inches): ___________________ Weight (Pounds): ______________________

Tobacco Use: ☐ Historical ☐ Current ☐ Former Date of Last Use: ____________________

Marijuana Use: ☐ Historical ☐ Current ☐ Former Date of Last Use: ____________________

Alcohol Use: ☐ Historical ☐ Current ☐ Former

Any History of Addiction Treatment: ____________________

Recreational Drug Use: ☐ Historical ☐ Current ☐ Former

Any History of Addiction Treatment ______________________

Past Surgical History

Pervious Surgeries other than amputation?

____

____

____

Allergies?

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____

____

Medical History

Please indicate if you have a history of any of the following. If you answer yes, please give more details.

Asthma ☐ Yes ☐ No

Peripheral Neuropathy ☐ Yes ☐ No

Peripheral Vascular Disease ☐ Yes ☐ No

Diabetes Type 1 ☐ Yes ☐ No

Diabetes Type 2 ☐ Yes ☐ No

Cancer ☐ Yes ☐ No

Chemotherapy Treatments ☐ Yes ☐ No

Radiation Therapy ☐ Yes ☐ No

Allograft Bone Transplant ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No

Systemic Inflammatory Disease ☐ Yes ☐ No

Transplant ☐ Yes ☐ No

Skin Infection ☐ Yes ☐ No

Osteomyelitis ☐ Yes ☐ No

Bone Deformity ☐ Yes ☐ No

History of Fracture ☐ Yes ☐ No

Rheumatoid Arthritis ☐ Yes ☐ No

Immunocompromised ☐ Yes ☐ No

Steroid Use ☐ Yes ☐ No

Allergy to Metal ☐ Yes ☐ No

Clotting Disorders of Family History of Clotting Disorders ☐ Yes ☐ No

____

Medical history more details: ____

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Mental Health

Have you ever suffered with depression required an anti-depressant: ☐ Yes ☐ No

If yes, are you still being treated? ☐ Yes ☐ No

If yes, what medication(s) are prescribed?

____

____

____

Do you currently see a psychologist or psychiatrist for support? ☐ Yes ☐ No

Are psychotropic medications a part of their treatment plan? ☐ Yes ☐ No

If yes, what medication(s) are prescribed?

____

____

Pain

Do you suffer from chronic pain? ☐ Yes ☐ No

Do you have pain while in your prosthesis? ☐ Yes ☐ No

Do you have pain while out of your prosthesis? ☐ Yes ☐ No

If yes to any of the above, please describe

____

____

Do you take any medication for this pain? ☐ Yes ☐ No

How long have you been on this medication? ____

Who is the prescribing provider for this medication? ______________________________________

Current Medications

Drug (Name): ____________________________ Dose (mg): _____________ Frequency: _________

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Drug (Name): ____________________________ Dose (mg): _____________ Frequency: _________

Drug (Name): ____________________________ Dose (mg): _____________ Frequency: _________

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Are you enrolled in any clinical trials? ☐ Yes ☐ No

Medical Provider Contact

Surgeon who performed amputation

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Phone Number: ______________ Fax: ______________

Primary Care Provider

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Phone Number: ______________ Fax: ______________

Prosthetist

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Phone Number: ______________ Fax: ______________

Physical Medicine and Rehab Physician/Physiatrist

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Phone Number: ______________ Fax: ______________

Pain Medicine Specialist

Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Phone Number: ______________ Fax: ______________

Have you had any recent images or your residual limb in the past five years?

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XRs ☐ No ☐ Yes Facility: _______________ Phone: _____________ Fax: ____________________

CTs ☐ No ☐ Yes Facility: _______________ Phone: _____________ Fax: ____________________

MRIs ☐ No ☐ Yes Facility: _______________ Phone: _____________ Fax: ____________________

Thank you for your time spent completing this questionnaire. We have one last request. Please sign up for My Health Connection, https://www.uchealth.org/access-my-health-connection/. My Health Connection (MHC) allows our team to streamline communication and ensure your privacy. Our patients are from all over the world and we want to be able to provide immediate communication from anywhere. Our team takes a multidisciplinary approach to your healthcare and this requires a high degree of coordination. In MHC you will be able to view upcoming appointments, send our team messages, and share valuable post-operative photos.

Ways to Return Questionnaire

Phone: 1-844-800-(LIMB) 5462
Fax: 720-553-0402
limbrestoration@uchealth.org

Anschutz Outpatient Pavilion
1635 Aurora Court
Mail Stop F722
Aurora, Colorado 80045

Thank you again for your interest in our program. Once the above steps are complete please call, 1-844-800- (LIMB) 5462, and we will schedule one on one time to review your history and discuss next steps. We look forward to hearing from you!

Sincerely,

Jason W. Stoneback, MD Director, Limb Restoration Program University of Colorado Hospital Department of Orthopedics

University of Colorado School of Medicine 1-844-800-LIMB (5462)

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