#### Hello,

Thank you for your interest in our Osseointegration Program. We appreciate you taking the time to complete the following document.

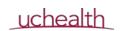
Personal Information			
Name (First, MI, Last):			
Date of Birth:			
Address:			
Street:			
City:		Zip Code:	
Email Address:			
		ome Number:	
Sex:	Gender:		
Preferred Language for medica	l terminology:		
Emergency Contact:			
Name:		Phone Number:	
Relationship:			
Are you currently employed?	□Yes □No		
If yes, what occupation:			
☐ Full Time ☐ Part Time ☐	Other:		
Living Arrangements			
How many stairs to enter home	:		
How many stairs to get to:			
Bedroom	Bathroom	Kitchen	







Home occupants:					
☐ Alone					
☐ Spouse/Partner					
□Other:					
Are home occupants able to provide assistance? $\square$ Yes $\square$ No					
Background					
How did you hear about osseointegration?					
How did you hear about the osseointegration program here at University of Colorado Hospital?					
Why are you seeking Osseointegration:					
Amputation and Prosthesis  Date of Amputation:  Cause of Amputation:					
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:					
Prosthesis components:					
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 <b>unaided</b> ?							
Are you currently un	ndergoing physical thera	apy? □ Yes □ No					
<u>Health History</u>							
Height (inches):		Weight (pounds):					
Tobacco use:	□Yes □No	If yes, date of last use:					
Marijuana use:	□Yes □No	If yes, date of last use:					
Alcohol use:	□Yes □No	If yes, how many drinks per week:					
Praying surgeries of							
J	other than amputation:						
Allergies (list with	reaction):						







#### **Medical History**

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

_	<u>Yes</u>	<u>No</u>	
[			Asthma
I			Peripheral neuropathy
[			Peripheral vascular disease
[			Diabetes
			$\square$ Type 1 $\square$ Type 2
I			Cancer
I			Chemotherapy treatment
I			Radiation therapy
[			Allograft bone transplant
I			Osteoporosis
[			Systemic inflammatory disease
I			Transplant
I			Skin Infection
I			Osteomyelitis
I			Bone deformity
I			History of Fracture
I			Rheumatoid arthritis
I			Immunocompromised
I			Steroid use
I			Allergy to metal
I			Clotting disorders or Family History of clotting disorders
Medical	l histor	y more	detail:







Have you ever suffe	ered with depression re	equiring a	an anti-depre	essant:	$\square$ Yes	$\square$ No	
If yes, are yo	ou still being treated:	□Yes	s $\square$ No				
If yes, what	medication(s) was pre						
<u>Pain</u>							
Do you suffer from	chronic pain?		□Yes	□No			
Do you have pain w	hile in your prosthesis	s?	□Yes	□No			
Do you have pain w	hile out of your prosth	hesis?	□Yes	□No			
If yes to any of the a	above, please describe	):					
Do you talso ony	digation for this mains	)	□V <sub>22</sub>	□N¹~			
	dication for this pain? we you been on this m		□Yes	□No			
	ive voli been on this m	nadicatio					
	prescribing provider fo						
	prescribing provider fo						
Who is the p	orescribing provider fo		edication?				
Who is the p  Current medication	orescribing provider fo	or this me	edication?				
Who is the p  Current medication	orescribing provider fo	or this me	edication?				
Who is the p  Current medication	orescribing provider fo	or this me	edication?				
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Who is the p  Current medication	orescribing provider fo	or this me	edication?				

**Medical Provider Contact** 







Surgeon who performed amputation	on		
Name:			
Address:			
City:			
Phone Number:	Fax:		
Primary Care Provider			
Name:			
Address:			
City:		Zip Code:	
Phone Number:	Fax:		
Prosthetist			
Name:			
Address:			
	State:		
Phone Number:	Fax:		
Physical Medicine and Rehab Physical	sician/ Physiatrist		
Name:			
Address:			
City:			
Phone Number:	Fax:		
Pain Medicine Specialist			
Name:			
Address:			
City:		Zip Code:	
Phone Number:	Fax:		







Have you had any recent images or your residual lin	mb in the past five ye	ars?
<b>XRs</b> □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 question Health Connection, <a href="https://www.uchealth.org/access-na">https://www.uchealth.org/access-na</a> allows our team to streamline communication and ensurant want to be able to provide immediate communication and this be able to view upcoming appointments, send our team ways to Return Questionnaire	ny-health-connection/.  ore your privacy. Our prication from anywhere requires a high degree	My Health Connection (MHC) patients are from all over the world . Our team takes a of coordination. In MHC you will

Phone: 1-844-800-(LIMB) 5462

Fax: 720-553-0402

<u>limbrestoration@uchealth.org</u>

**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)





