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? Facebook

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: ☐ Never ☐ Current ☐ Former Date of Last Use: _____

Marijuana Use: ☐Never ☐ Current ☐ Former Date of Last Use: _____

Alcohol Use: ☐ Never ☐ Current ☐ Former

Any History of Addiction Treatment: _____

Recreational Drug Use: ☐ Never ☐ 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: _____

Drug (Name): _____ Dose (mg): _____ Frequency: _____

Drug (Name): _____ Dose (mg): _____ Frequency: _____

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 Please provide phone and fax number for treating providers. Failure to provide complete information will delay intake process.

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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