



# Patient Care Pathway

**First Post-Fitting Assessment  
Sample – July 2013**

## Add First Post Fitting Assessment

Step: **1** 2 3 4

### Medical Info

Today's date:


07/25/2013



Client ID:

Client email:

Gender:

Please select... 

Date of birth:

03/11/1983



i-limb product serial number:

Prosthetist Name:

Prosthetist Practice Name:

City/State:

Name of person completing form, if other than patient:

How long have you been wearing your i-limb prosthesis?

Do you have pain in your affected hand?  Yes  No

If YES, Please rate the level of pain:

If YES, please explain:

- |   |                                    |                                   |
|---|------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Burning | <input type="checkbox"/> Sharp     | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Numbness/Tingling  | <input type="checkbox"/> Crushing  | <input type="checkbox"/> Shooting |
| <input type="checkbox"/> Throbbing          | <input type="checkbox"/> Cramping  | <input type="checkbox"/> Dull     |
| <input type="checkbox"/> Aching             | <input type="checkbox"/> Tightness | <input type="checkbox"/> Other    |

Do you experience over use pain in your affected arm?  Yes  No

Do you have any problems putting on and removing the prosthesis?  Yes  No

Have you returned to work?  Yes  No

How long after you recieved your prosthesis did you return to work?

Save & Quit →

Next

## Add First Post Fitting Assessment

Step: **1** 2 3 4

### Questionnaire TAPES

The following two sets of questions are from the Trinity Amputation and Prosthesis Experience Scales (TAPES) with permission from Dr. Pamela Gallagher, of the Dublin Psychoprosthetics Group.

Below are written a series of statements concerning amputation or wearing of a prosthesis. There are no right or wrong answers.

Please answer every item as honestly as you can. Your responses will remain strictly confidential.

Please read through each statement carefully. Then select the number beside the statement that shows how strongly you agree or disagree with it:

	Strongly disagree	Disagree	Agree	Strongly agree	Not applicable
3. I feel that I have dealt successfully with this trauma in my life...	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 9
7. I find it easy to talk about my prosthesis...	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 9
13. Being an amputee means that I can't do what I want to do...	<input type="radio"/> 4	<input type="radio"/> 3	<input type="radio"/> 2	<input type="radio"/> 1	<input type="radio"/> 9

Save & Quit ↗

Back

Next

## Add First Post Fitting Assessment

Step: **1** **2** **3** **4**

### Questionnaire TAPES (part 2)

Please select the number that represents the extent to which you are satisfied or dissatisfied with each of the different aspects of your prosthesis mentioned below.	Not Satisfied	Satisfied	Very Satisfied
Color	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Shape	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Appearance	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Weight	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Usefulness	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Reliability	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Fit	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
Comfort	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

Please select the number (0 - 10) that best describes how satisfied you are with your prosthesis

1   
  2   
  3   
  4   
  5   
  6   
  7   
  8   
  9   
  10

To what extent are you satisfied or dissatisfied with the noise your prosthesis creates:

Please select...

Do you find any limitations to using your i-limb prosthesis? (Select all that apply)

- No limitations
- Physical Discomfort
- Too Hot
- Medical Reasons
- Creates rash/sores
- Pain
- Lack of training/support
- Time required to put on/remove
- Difficult/tiring to use
- Too heavy
- Appearance
- Too bulky
- Damages Clothing
- Fear of damaging the device
- Need repair
- Other

Other

Save & Quit ↗

## Add First Post Fitting Assessment

Step: **1** 2 3 4

### Occupational Therapy

Did you receive any Occupational therapist (OT) training to learn to use your i-limb prosthesis?

Yes

No

If yes, approximately how many total hours of training did you receive?

If yes, please indicate the time that OT training began during the fitting of your i-limb prosthesis.

Please select...

How useful did you find therapy training with your prosthesis? (0 = not at all, 5 = extremely useful)

Please select...

How could your i-limb prosthesis be improved to better meet your needs?

Other comments

## Add First Post Fitting Assessment

Thank you for completing the Post-Fitting Assessment.

---

Click to download Treatment Plan [Treatment Plan](#) ↗

---

[Click here to return to My Portal](#)