TOTAL JOINT HEALTH

OUTCOMES TRACKER – HIP & KNEE

Please complete all information at both EVALUATION & DISCHARGE of patient.
Upon discharge of patient, please return form to jagsortho@gmail.com.

1. PATIENT NAME: _____ Start of Care: ____/____/____

Discharge of Care: ____/____/____

2. PATIENT PHONE #: _____ **3.** PHYSICIAN:_____

4. PROCEDURE: LEFT RIGHT _____

5. DATE OF SURGERY: _____/_____/_____ **6.** DISRUPTION TO CARE: _____

7. FUNCTIONAL OASIS SCORE (Medicare only): EVAL =____/ 37 D/C =____/ 37

8. KNEE SOCIETY SCORE (Non-Medicare-Knee Only): EVAL = _____ D/C = _____

9. CIRCUMFERENCE: 10cm above joint line Left_____cm Right_____cm

Joint line Left_____cm Right_____cm

Tibial tuberosity Left_____cm Right_____cm

10. CURRENT WB STATUS (circle): *NWB PWB* _____*% or lbs WBAT*

11. TIMED UP & GO TEST: EVAL = _____sec D/C =_____sec

EVAL assistive device used:_____ D/C assistive device used: _____

☐ Check here if patient requires assistance or is unable to complete TUG test. (*If TUG > 30sec, pt is at increased risk for falls)

12. BALANCE: (a) Functional Reach: EVAL = _____ in _____in

(2 Trials) D/C = _____ in _____in

(b) Single Leg Stance (SLS): EVAL = Left _____ _____ sec Right _____ _____ sec

(2 Trials) D/C = Left _____ _____ sec Right _____ _____ sec

*If Functional Reach < 10 inches or SLS < 5 seconds, patient is at increased risk of fall.

13. GAIT DISTANCE CATEGORY: EVAL = 1 2 3 4 D/C = 1 2 3 4

EVAL assistive device used:_____ D/C assistive device used:_____

CATEGORY: 1 = 0'-100'ft. 2 = 101'-200'ft. 3 = 201'300'ft. 4 = 301'-400+'ft. (all on level surfaces)

14. ADDITIONAL COMMENTS :

********** **COMPLETE ADDITIONAL INFO FOR KNEE PATIENTS ONLY** **********

		LEFT	**RIGHT**
At Evaluation:	PROM (supine):	**Knee ext** = _____°	**Knee ext** = _____°
		Knee flex = _____°	**Knee flex** = _____°
	MMT (seated):	**Knee ext**= ____/5	**Knee ext** = ____/5
		Knee flex= ____/5	**Knee flex** = ____/5
At Discharge:	PROM (supine):	**Knee ext** = _____°	**Knee ext** = _____°
		Knee flex = _____°	**Knee flex** = _____°
	MMT (seated):	**Knee ext**= ____/5	**Knee ext** = ____/5
		Knee flex= ____/5	**Knee flex** = ____/5

15. Patient D/C to: ☐ Outpatient PT _____(Clinic name/City) ☐ OTHER _____

_____ (_____) _____ - _____

Your Name (printed) / Title Phone Number