

Facility: _____

Dossier : _____
 Nom, Prénom : _____
 Date de naissance : _____ ☐ F ☐ M
 aaaa-mm-jj
 NAM : _____ Exp. _____
 aaaa-mm
 Nom de la mère : _____

PREOPERATIVE PHYSIOTHERAPY SCREENING - TKR-THR CLIENTELE

- ☐ Total knee replacement
☐ Unicompartmental knee replacement ☐ Left ☐ Right ☐ Bilateral
☐ Total hip replacement

Name of your surgeon: _____ Expected date of surgery: _____

yyyy-mm-dd

Is this your first surgery for this kind of prosthesis? ☐ Yes ☐ No

HEALTH	
What is your height? _____ (feet) or _____ (meters)	
Do you have any other known diseases? Specify: _____	☐ Yes ☐ No
Do you manage your medications yourself?	☐ Yes ☐ No
Do you ever forget recent facts? For example: the names of people around you, dates and times of your appointments, etc.?	☐ Yes ☐ No ☐ Sometimes
Do you ever forget day-to-day things? For example: taking your medications, turning off the stove, etc.?	☐ Yes ☐ No ☐ Sometimes
Do you ever feel disoriented in a familiar place?	☐ Yes ☐ No ☐ Sometimes
Do you ever forget what time of the day it is? (morning, midday, evening)	☐ Yes ☐ No ☐ Sometimes
What is your ability to listen to and understand new explanations?	☐ Good ☐ Decreased
Do you feel able to follow a written exercise program that will be explained to you?	☐ Yes ☐ No ☐ I don't know
Do you suffer from urinary incontinence?	☐ Yes ☐ No ☐ Sometimes
Have you lost weight in the past 6 months WITHOUT TRYING to lose this weight? (If the patient reports a weight loss but gained it back, consider it as NO weight loss).	☐ Yes ☐ No
Have you been eating less than usual FOR MORE THAN A WEEK?	☐ Yes ☐ No

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SOCIAL HISTORY			
Do you live alone?	☐ Yes ☐ No	With whom do you live?	☐ Spouse ☐ Children ☐ Other(s) : _____
Do you have a caregiver available for your return home?		☐ Yes	Age of the caregiver: ____ years ☐ No
Is your caregiver able to help you during the first few days after surgery?		☐ Yes	☐ No

CURRENT FUNCTIONAL CAPACITIES				
For each activity, write an "X" in the box that corresponds to your current level of capacity:				
Activities		You are autonomous	You are autonomous with difficulty	You need help from someone
Transfers	Sitting to standing up OR Standing to sitting down			
	Lying down to sitting OR Sitting to lying down			
	Turning in your bed			
Dressing	Getting dressed			
	Undressing			
Hygiene	Washing in the bath			
	Washing in the shower			
	Going to the toilet			
Food	Eating			
	Preparing meals			
Household	Housekeeping			

WALKING	
External aid	☐ No external aid ☐ Standard cane ☐ Quadripod cane ☐ Walker ☐ Walker with wheels ☐ Wheelchair ☐ Other: _____
Endurance	I can walk without resting for a distance of _____ feet or _____ metres. I can walk without resting for _____ minutes.

STAIRS	
Which of the following aids do you currently use on stairs?	☐ No aid ☐ Handrail ☐ Cane ☐ Help of a person ☐ Other: _____
How do you go up the stairs?	☐ Alternating (left foot, right foot, etc.) ☐ Non-alternating (always the same foot first)
How do you go down the stairs?	☐ Alternating (left foot, right foot, etc.) ☐ Non-alternating (always the same foot first)

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ENVIRONMENT	
House	
What type of house do you live in?	☐ Bungalow ☐ Cottage ☐ Apartment or condominium ☐ Private residence ☐ Other: _____
Is there an elevator?	☐ Yes ☐ No
Which floor is your bedroom on?	☐ Ground floor ☐ 2 nd floor ☐ Basement
Stairs	
Are there interior stairs to the basement?	☐ Yes ☐ No Number of steps: _____
Is there a handrail?	☐ Yes ☐ No
Are there interior stairs to the 2nd floor?	☐ Yes ☐ No Number of steps: _____
Is there a handrail?	☐ Yes ☐ No
Are there exterior stairs?	☐ Yes ☐ No Number of steps: _____
Is there a handrail?	☐ Yes ☐ No
Bathroom	
Where is it?	☐ Ground floor ☐ 2nd floor ☐ Basement
What shape is the toilet bowl?	☐ Elongated ☐ Round ☐ Don't know
Can you use the vanity as a solid support to help you sit or stand up?	☐ Yes ☐ No
When you are sitting on the toilet seat:	☐ Your knees are HIGHER than your hips ☐ Your knees are AT THE SAME HEIGHT as your hips ☐ Your knees are LOWER than your hips
What type of shower do you have?	☐ Shower in bathtub ☐ Shower stall
What kind of bathtub do you have?	☐ Standard ☐ Other (podium, clawfoot, free-standing, etc.)
Are you currently able to step over the edge of the tub?	☐ Yes ☐ No

User's signature: _____ Date: _____

yyyy-mm-dd

User's contact information: _____

Address

Phone number

FOR USE BY THE PRACTITIONER	
Request needed for preoperative physiotherapy assessment at home: ☐ Yes ☐ No	
Comments: _____	
Practitioner's Name (block letters) _____	
☐ PHT ☐ TRP	☐ Nurse
Signature: _____	Date: _____
☐ PHT ☐ TRP	☐ Nurse yyyy-mm-dd
PLEASE SEND THE FORM BY FAX :	
☐ CLSC Châteauguay 450-699-3508	☐ CLSC Beauharnois 450-371-4689
☐ CLSC Jardins-du Québec 450-454-2909	☐ CLSC Valleyfield 450-371-4689
☐ CLSC Kateri 450-659-1642	☐ CLSC Saint-Polycarpe 450-265-3556
☐ CLSC Vaudreuil-Dorion 450-455-6192	☐ CLSC Huntingdon 450-264-6801