

SCREENING FORM FOR PARTIAL-HAND PROSTHETICS

Videos, photographs, and forms should only be submitted to Össur via email using our customer service email address (ossursa@ossur.com).

Clinician name	E-Mail	Phone
Clinic	City	Postcode
Patient identifier*	Patient date of birth	
Cause of partial-hand limb difference? Trauma Congenital Vascular compromise Other: _____	Dominant hand Right Left Ambidextrous	
Medical condition of the hand is stable? Yes No	Screening which hand for device Right Left Bilateral	
Date of limb loss (mm/dd/yy) _____ Date of final surgical procedure (mm/dd/yy) _____	Has the patient tried other prosthetic intervention? Yes No	
Is the user currently undergoing hand therapy? Yes No Have all therapy goals been achieved? Yes No		
Does the user have any of the following symptoms? Volume fluctuation Limited range of motion Sensation loss or hypersensitivity Weakness Chronic edema Joint contracture Skin concerns (scar, grafting, fragile) Other: _____		

<p>PHOTOS: REQUIRED PHOTOS MUST INCLUDE BOTH HANDS</p>	<p>VIDEOS: Take video of the patient's hand demonstrating full flexion and extension range of motion from a sagittal and palmar view.</p>
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Ensure crease lines of affected finger(s) are visible in photo.
If not visible, mark crease lines on image.

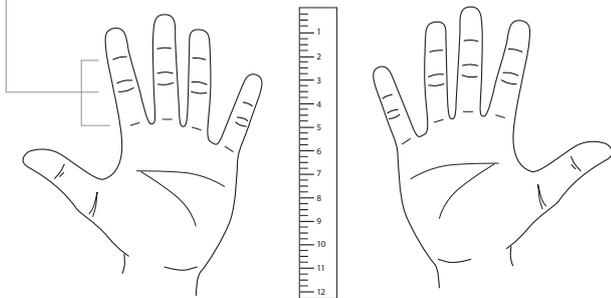


PHOTO A – fingers extended, palmar view

Ruler markings have to be clearly visible in the photo.

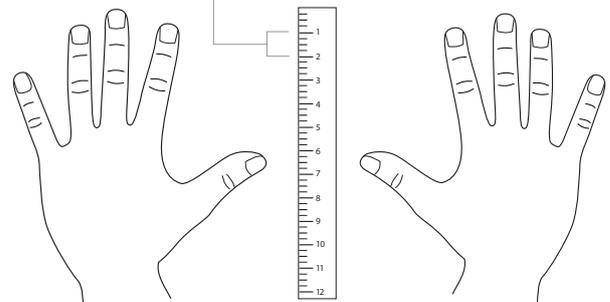


PHOTO B – fingers extended, dorsal view

PATIENT GOALS – Please list the top 5 goals the device(s) may assist your patient in achieving:

ADLs (self care, dressing, buttons, hygiene, etc.)	Occupation/employment _____
Preparing meals	Using tools <i>impact, vibratory, and/or bilateral required</i>
Driving	Weightlifting/other exercise _____
Household maintenance	Writing/typing _____
Childcare _____	Musical instrument _____
Animal care _____	Hobbies _____
Other _____	

*Please make sure to use coded patient identifier, not patient name.