NAKED PROSTHETICS

SCREENING FORM FOR PARTIAL-HAND PROSTHETICS

Videos, photographs, and forms should only be submitted to Össur using a transmission method that is data protection compliant. Please contact our customer service (ukprosthetics@ossur.com) if you do not have data transfer access with us.

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: _____

PHOTOS:

REQUIRED PHOTOS
MUST INCLUDE BOTH HANDS

VIDEOS:

Take video of the patient's hand demonstrating full flexion and extension range of motion from a sagittal and palmar view.

Ensure crease lines of affected finger(s) are visible in photo. If not visible, mark crease lines on image.

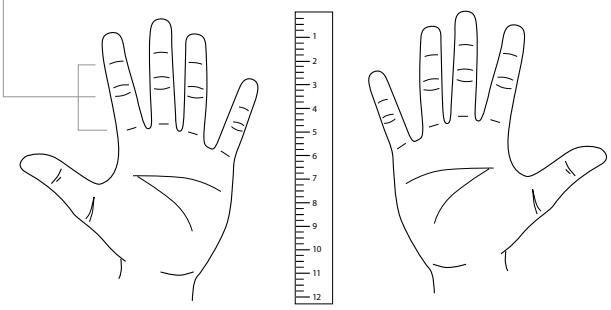

PHOTO A – fingers extended, palmar view

Ruler markings have to be clearly visible in the photo.

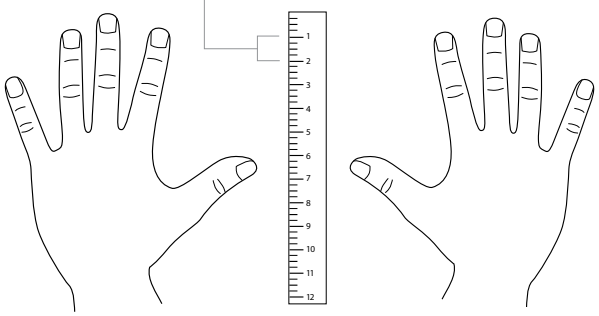

PHOTO B – fingers extended, dorsal view

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

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

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

Reset