Mechanical Upper Limb Solutions Screening Form

Return via email to _____.

Facility Information

Clinic / Customer #: _____

Clinician Name: _____

Email: _____

Phone: _____

Shipping Address (PO Box): _____

_____

City, State / Province: _____

Zip Code / Postal Code: _____

Patient Information

Patient Identifier (please do not include the patient's name): _____

Cause of partial-hand limb difference?

- ☐ Trauma
- ☐ Vascular compromise
- ☐ Congenital
- ☐ Other: _____

Medical condition of the hand is stable? ◯ Yes ◯ no

Date of limb loss (m/d/yy): _____

Date of final surgical procedure (m/d/yy): _____

Patient is currently in hand therapy? ◯ Yes ◯ no

Have all therapy goals been achieved? ◯ Yes ◯ no

Dominant hand:

◯ Right ◯ Left ◯ Ambidextrous

Screening which hand for device:

◯ Right ◯ Left ◯ Bilateral

Has the patient tried other prosthetic intervention?

◯ Yes ◯ No

Are you seeking a referral to a certified prosthetist?

◯ Yes ◯ No

Is the patient experiencing any of the following?

- ☐ Volume fluctuation
- ☐ Chronic edema
- ☐ Joint contracture
- ☐ Limited range of motion
- ☐ Sensation loss or hypersensitivity
- ☐ Weakness
- ☐ Skin concerns (scar, grafting, fragile)
- ☐ Other (explain): _____

Photos & Videos

Photos - Required photos must include both hands.

Videos - Take video of the patient's hand demonstrating **full flexion** and **extention** 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.

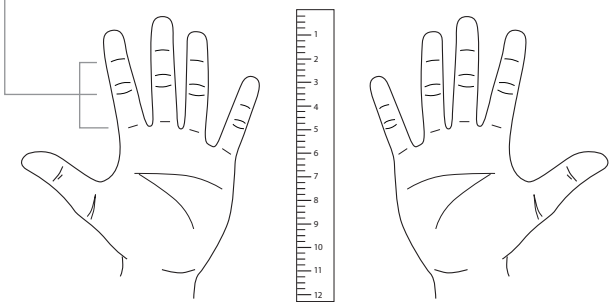

Photo A - fingers extended, palmar view

Ruler marks must be clear in image.

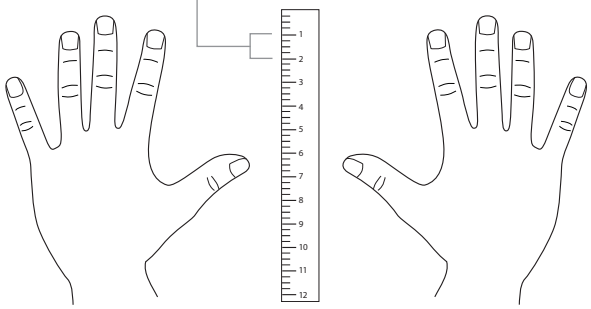

Photo B - fingers extended, dorsal view

Patient Goals - Please select the top 5 goals the device(s) may assist your patient in achieving.

- ☐ ADLs (self care, dressing, buttons, hygiene, etc.)
- ☐ Food preparation
- ☐ Driving
- ☐ Household maintenance
- ☐ Tool use (impact, vibratory, and/or bilateral required)
- ☐ Typing
- ☐ Childcare: _____
- ☐ Animal care: _____
- ☐ Occupation/employment: _____
- ☐ Weightlifting/other exercise: _____
- ☐ Musical instrument: _____
- ☐ Hobbies: _____
- ☐ Other: _____