OATA

For internal use only

Form identification no. _____

Lower Extremity Injuries Discharge Report

A. Patient Demographics

Practitioner Identification No.: _____ Patient Identification No.: _____
(Please provide a random patient identifier number)

1. Gender: ☐ Male ☐ Female

2. Age Group: ☐ 0-14 ☐ 15 – 24 ☐ 25 – 34 ☐ 35 – 44 ☐ 45-54 ☐ 55-64 ☐ 65+

B. Clinical Information

3. (a) Patient completed Program of Care: ☐ Yes or (b) Patient did not return/self-discharged from Program of Care: ☐ Yes

4. (a) Specify date of first visit: mm | dd | yyyy

   (b) Specify date of last visit: mm | dd | yyyy

5. Please select one injury:

Acute Ankle Sprain	☐ Left	☐ Right
Patellar Tendinopathy	☐ Left	☐ Right
Patellofemoral Syndrome	☐ Left	☐ Right

6. (a) At Assessment

   Describe patient's current self-reported symptoms:

   Function ☐ Pain ☐ Subjective instability (feeling of giving way) ☐ Swelling

Difficulty weight bearing	☐ Yes	☐ No
Difficulty stair climbing	☐ Yes	☐ No
Difficulty squatting	☐ Yes	☐ No

   ☐ Other (please specify)

   (b) At Discharge

   Describe patient's current self-reported symptoms:

   Function ☐ Pain ☐ Subjective instability (feeling of giving way) ☐ Swelling

Difficulty weight bearing	☐ Yes	☐ No
Difficulty stair climbing	☐ Yes	☐ No
Difficulty squatting	☐ Yes	☐ No

   ☐ Other (please specify)

7. (a) At Assessment

   Summary of physical findings (includes pertinent negative findings):

☐ Weight bearing	☐ 100%	☐ 75%	☐ 25%	☐ 0%
☐ ROM	☐ 100%	☐ 75%	☐ 25%	☐ 0%
☐ Instability	☐ Yes	☐ No		
☐ Swelling	☐ Yes	☐ No		

   ☐ Assistive devices (please specify)

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7. (b) At Discharge

Summary of physical findings (includes pertinent negative findings):

☐ Weight bearing	☐ 100%	☐ 75%	☐ 25%	☐ 0%
☐ ROM	☐ 100%	☐ 75%	☐ 25%	☐ 0%
☐ Instability	☐ Yes	☐ No		
☐ Swelling	☐ Yes	☐ No		
☐ Assistive devices (please specify)				

8. (a) Summary of physical findings at discharge:

(b) Summary of significant changes from initial assessment:

9. (a) At Assessment

Describe patient's limitations in Activities of Daily Living:

☐ Child care	☐ Hobbies	☐ Other (please specify)
☐ Housekeeping	☐ Self-care	
☐ Sleep disturbance	☐ Sports/Leisure activities	

(b) At Discharge

Describe patient's limitations in Activities of Daily Living:

☐ Child care	☐ Hobbies	☐ Other (please specify)
☐ Housekeeping	☐ Self-care	
☐ Sleep disturbance	☐ Sports/Leisure activities	

10. (a) At Assessment

Record scores for the:

A. Lower Extremity Functioning Scale (LEFS) /80

B. Numeric Pain Rating Scale (NPRS) /10 (e.g. no pain = 0, worst possible pain = 10)

(b) At Discharge

Record scores for the:

A. Lower Extremity Functioning Scale (LEFS) /80

B. Numeric Pain Rating Scale (NPRS) /10 (e.g. no pain = 0, worst possible pain = 10)

11. Are there any complicating factors (yellow flags) that may delay recovery: ☐ Yes ☐ No
If yes, identify:

☐ Believes hurt equals harm	☐ Home environment concerns	☐ Fears/avoids activity
☐ Low mood/social withdrawal	☐ Prefers passive treatments	☐ Other (please specify)

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12. Please indicate if any of the following are required:

☐ Additional treatments	☐ Yes	☐ No
☐ Additional re-assessments	☐ Yes	☐ No
☐ Referrals	☐ Yes	☐ No

If yes, to whom were the referrals made?
(e.g. other health professionals)
[Do not provide names]

C. Summary of Care Delivered

13. Acute Ankle Sprain (AS)

	Program Weeks	
(a) Program of Care Interventions Supported by Evidence	Weeks 1-3	Weeks 4-8
Cryotherapy	☐	☐
Manipulation	☐	☐
Passive joint mobilization	☐	☐
Proprioception/functional training	☐	☐
Range of motion and strengthening exercises	☐	☐
(b) Other Interventions Not Supported by Evidence and Not Recommended		
Laser therapy	☐	☐
Prolonged immobilization (for greater than 72 hours)	☐	☐
Ultrasound	☐	☐
Hyperbaric oxygen	☐	☐

14. Patellar Tendinopathy (PT)

(a) Program of Care Interventions Supported by Evidence	Weeks 1-6	Weeks 7-12
Therapeutic exercise	☐	☐
(b) Other Interventions Not Supported by Evidence and Not Recommended		
Friction or ultrasound	☐	☐
Deep transverse friction massage	☐	☐

15. Patellofemoral Syndrome (PF)

(a) Program of Care Interventions Supported by Evidence	Weeks 1-6	Weeks 7-12
Therapeutic exercise	☐	☐
Mobilization	☐	☐
Acupuncture	☐	☐
(b) Other Interventions Not Supported by Evidence and Not Recommended		
Deep transverse friction massage (for iliotibial band syndrome)	☐	☐
McConnell Regimen	☐	☐
Taping	☐	☐
Ultrasound	☐	☐

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16. Visits Summary:

(a) Acute Ankle Sprain

Total number of treatment visits during Program of Care: Weeks 1-3 ___ Weeks 4-8 ___

(b) Patellar Tendinopathy

Total number of treatment visits during Program of Care: Weeks 1-6 ___ Weeks 7-12 ___

(c) Patellofemoral Syndrome

Total number of treatment visits during Program of Care: Weeks 1-6 ___ Weeks 7-12 ___

17. Total number of treatment visits: _____

» Submit

Under no circumstances is private or confidential personal patient information to be disclosed to the OATA or third party.

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