OATA

For internal use only

Form identification no. ________________

Upper 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: | |

   (b) Specify date of last visit: | |
5. Please select one injury:

   Carpal Tunnel Syndrome ☐ Left ☐ Right
   Lateral Epicondylitis ☐ Left ☐ Right
   Rotator Cuff Injury ☐ Left ☐ Right
6. (a) Summary of physical findings at discharge:

   (b) Summary of significant changes from initial assessment:
7. Describe any changes in health status (e.g. changes in medication type or dosage):
8. (a) At Assessment

   Indicate nature of patient's pain (choose all that apply):

   ☐ Pain in shoulder
   ☐ Numb, tingling sensation over hand and into fingers
   ☐ Other (please specify)
   ☐ Pain in wrist or hand
   ☐ Pain lateral elbow
   ☐ Shooting pain, forearm and hand

   (b) At Discharge

   Indicate nature of patient's pain (choose all that apply):

   ☐ Pain in shoulder
   ☐ Numb, tingling sensation over hand and into fingers
   ☐ Other (please specify)
   ☐ Pain in wrist or hand
   ☐ Pain lateral elbow
   ☐ Shooting pain, forearm and hand

Ontario Athletic Therapist Association
140 Allstate Parkway, Suite 302 Markham ON L3R 5Y8, Tel: (905) 946-8080
www.ontarioathletictherapists.org

Upper Extremity Injuries Discharge Report

9. (a) At Assessment

Describe patient's limitations in Activities of Daily Living:

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

(b) At Discharge

Describe patient's limitations in Activities of Daily Living:

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

10. (a) At Assessment

Record QuickDASH scores:
QuickDASH Disability/Symptom Score: _______ QuickDASH Work Module Score: ________

(b) At Discharge

Record QuickDASH scores:
QuickDASH Disability/Symptom Score: _______ QuickDASH Work Module Score: ________

11. Has the patient physically returned to pre-injury level of overall function? ☐ Yes ☐ No

12. Are there any complicating factors (yellow flags) that may delay recovery? ☐ Yes ☐ No

If yes, please specify:

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

13. 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

Program of Care Interventions Supported by Evidence

<u>Program Weeks</u>

14. Please indicate Program of Care component delivered:

		Weeks 1-6	Weeks 7-12
(a) Carpal Tunnel Syndrome (CTS)	Manipulation	☐	☐
	Mobilization	☐	☐
	Night splinting	☐	☐
	Ultrasound	☐	☐

Ontario Athletic Therapist Association
140 Allstate Parkway, Suite 302 Markham ON L3R 5Y8, Tel: (905) 946-8080
www.ontarioathletictherapists.org

Upper Extremity Injuries Discharge Report

		Weeks 1-6	Weeks 7-12
(b) Lateral Epicondylitis (LE)	Acupuncture	☐	☐
	Exercises	☐	☐
	Manipulation	☐	☐
	Mobilization	☐	☐
	Ultrasound	☐	☐
(c) Rotator Cuff Injury (RCI)	Exercises	☐	☐
	Massage	☐	☐
	Mobilization	☐	☐

Program of Care Interventions Not Supported by Evidence and Not Recommended

15. Please indicate Program of Care component delivered:

Program Weeks

	Weeks 1-6	Weeks 7-12
Acupuncture (CTS, RCI)	☐	☐
Braces (CTS)	☐	☐
Electromagnetic therapy (RCI)	☐	☐
Electrotherapy (RCI)	☐	☐
Full time splinting (CTS)	☐	☐
Ionization (LE)	☐	☐
Laser (CTS, LE, RCI)	☐	☐
Magnets (CTS)	☐	☐
Needle aspiration (RCI)	☐	☐
Nerve gliding exercises (CTS)	☐	☐
Pulsed electromagnetic field (LE)	☐	☐
Rebox (LE)		
Shockwave therapy (RCI)	☐	☐

16. Visits Summary

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

17. Total number of treatment visits: _____

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