

Lower Extremity Evaluation:

Guidelines for the usage of this evaluation form are as follows:

- 1) Basic information is entered as indicated on the form including patient's name, MPI#, Division, Unit, Date of Admission, Date of Birth and Age.
- 2) Treating Diagnoses/Chief Complaint - indicate the reason for referral.
- 3) History of Leg Problems – Prior Leg Surgeries - Note previous leg conditions and history of injuries or surgeries.
- 4) History- All other pertinent diagnoses.
- 5) Anticipated Occupation Upon Discharge: If know, note the type of work that the patient will be returning to as it applies to standing, kneeling, sitting, walking, etc.
- 6) Hand Dominance: Note Left, Right or Both. Height and Weight in inches and pounds.
- 7) Leg Length: Measure leg length and note what body landmarks were used to measure from and to.
- 8) Gait Deviations & Assistive Devices Used: Note any gait deviations, distance, cadence, assistance needed and type of assistive devices used.
- 9) Posture: Note postural deviations from normal. If none, write normal.
- 10) ROM (Range of Motion) & Strength Chart: Measure available ROM with goniometer or other measuring device. Determine patient's strength using manual muscle testing and grades 0-5 out of a possible 5. Test all lower extremity functions bilaterally.
- 11) Pain (location, type & intensity): Describe the location of the pain, if it radiates to another body area, the type of pain and the intensity of the pain using the 1 to 10 scale (1 being the least and 10 being the most). Note if the pain changes throughout the day or with specific activities. Note any modalities, medications, positions, etc. that decrease or increase the pain.
- 12) Sensation, Reflexes & Proprioception: Test and describe results.
 - A. Light Touch – Use a cotton ball or hair brush to rub lightly against the patient's skin. Intact should be checked if response is correct to both the feel the light touch and to identify correct location.
 - B. Sharp/Dull – Apply stimulus, either sharp or dull randomly and request patient to respond sharp or dull. "Intact" response is the ability to distinguish the sensations correctly. "Decreased"

indicates patient does not distinguish the sensations consistently. Indicate areas involved.

C. Reflexes – Test for basic reflexes as appropriate including Babinski, patellar, biceps, and triceps. Check for positional tone and observe for evidence of abnormal reflexes in motor activities.

D. Hot/Cold – Perception of Hot and Cold.

E. 2 Point Discrimination – Using a paper clip or discriminator, test client's ability to discriminate between one and two points stimulated on the skin at one time. Measure the distance between points. "Intact" response is the ability to distinguish two points.

F. Paresthesia – Test for areas of decreased sensation or lack of sensation

G. Proprioception – Test the client's ability to determine joint position in sense and check those areas listed if the client is able to successfully complete task with accuracy.

13) Endurance – Describe the length of time that a person can do a certain activity. Note specifically the patient's ability to ambulate on unit, in building, on grounds or in the community.

14) Palpation (soft tissue & bony) & Joint Integrity – Describe irregularities in soft tissue, joints or bony structures. Note stability of the joints involved and mobility or hypermobility.

15) Circulation/Edema – Measure circumference of leg at specific points. Measure from a specific land mark, i.e. base of the patella, lateral malleolus. Note measurements in inches or centimeters.

16) Special Tests – Describe any other special test results.

17) Assessment: A summary of findings from the evaluation should be written with emphasis on strengths and weaknesses. For re-assessments note patient's response to treatment should be included.

18) Recommendations: Patient needs will be identified and priorities recommended.

18) Goals: Check off appropriate goal from the choices listed or add another goal next to "other".

19) Treatment Plan: Check off appropriate treatments from the choices listed or describe another treatment next to "other."

20) Frequency of Treatment: Write recommended number of times patient will be seen per week and include which days of the week the patient will be seen.

21) Assessment and Treatment Plan discussed with Patient-Indicate yes or no. Indicate yes or no. If no, explain why.

22) The evaluating therapist should sign, print name and title and date the evaluation.