

Osseointegration Pre-Screening Questionnaire

Hello,

Thank you for your interest in our Osseointegration Program. We appreciate you taking the time to complete the following document. Any sections that are incomplete, may result in delayed processing time.

Personal Information

Name (First, MI, Last): _____

Date of Birth: _____

Address (Street): _____

City: _____ State _____ Zip Code _____

Email: _____

Mobile Number: _____ Home Number: _____

Sex: _____ Gender _____

Pronoun Preference: _____

Preferred Language for Medical Terminology: _____

Emergency Contact Name: _____

Phone Number: _____

Relationship: _____

Are you currently employed? Yes No

If yes, what occupation? _____

Full Time Part Time Other: _____

Living Arrangements

How many stairs are in your home?

Entrance: _____ Bedroom: _____ Bathroom: _____ Kitchen _____

Home Occupants?

Alone Spouse/Partner Other: _____

Are home occupants able to provide assistance? Yes No

Background

How did you hear about osseointegration? Choose an item.

Cause of Amputation? _____

Date of Amputation: _____

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Site of Amputation: Right Left Both
 Above Knee Below Knee Above Elbow Below Elbow

(If both sides, provide details as needed) : _____

Do you have any internal hardware in your residual limb? Yes No

Prosthesis Components: _____

Number of sockets used since initial amputation? _____

Any problems/ concerns with your sound limb? Yes No

Mobility Aids used in prosthesis? _____

How many hours per day do you wear prosthesis? _____

If using step-counter, how many steps per day with in your prosthesis? _____

How far can you comfortably walk **unaided**? _____

Are you currently undergoing physical therapy? Yes No

Health History

Height (inches): _____ Weight (Pounds): _____

Nicotine Use: Never Current Former Date of Last Use: _____

Marijuana Use: Never Current Former Date of Last Use: _____

Alcohol Use: Never Current Former

Any History of Addiction Treatment: _____

Recreational Drug Use: Never Current Former

Any History of Addiction Treatment _____

Past Surgical History

Pervious Surgeries other than amputation?

Allergies?

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Medical History

Please indicate if you have a history of any of the following. If you answer yes, please give more details.

- Asthma Yes No
- Peripheral Neuropathy Yes No
- Peripheral Vascular Disease Yes No
- Diabetes Type 1 Yes No
- Diabetes Type 2 Yes No
- Cancer Yes No
- Chemotherapy Treatments Yes No
- Radiation Therapy Yes No
- Allograft Bone Transplant Yes No
- Osteoporosis Yes No
- Systemic Inflammatory Disease Yes No
- Transplant Yes No
- Skin Infection Yes No
- Osteomyelitis Yes No
- Bone Deformity Yes No
- History of Fracture Yes No
- Rheumatoid Arthritis Yes No
- Immunocompromised Yes No
- Steroid Use Yes No
- Allergy to Metal Yes No
- Clotting Disorders of Family History of Clotting Disorders Yes No

Medical history more details: _____

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Mental Health

Have you ever suffered with depression required an anti-depressant: Yes No

If yes, are you still being treated? Yes No

If yes, what medication(s) are prescribed?

Do you currently see a psychologist or psychiatrist for support? Yes No

Are psychotropic medications a part of their treatment plan? Yes No

If yes, what medication(s) are prescribed?

Pain

Do you suffer from chronic pain? Yes No

Do you have pain while in your prosthesis? Yes No

Do you have pain while out of your prosthesis? Yes No

If yes to any of the above, please describe

Do you take any medication for this pain? Yes No

How long have you been on this medication? _____

Who is the prescribing provider for this medication? _____

Current Medications

Drug (Name): _____ Dose (mg): _____ Frequency: _____

Drug (Name): _____ Dose (mg): _____ Frequency: _____

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Drug (Name): _____ Dose (mg): _____ Frequency: _____

Drug (Name): _____ Dose (mg): _____ Frequency: _____

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Are you enrolled in any clinical trials? Yes No

Medical Provider Contact

Surgeon who performed amputation Please provide phone and fax number for treating providers.
Failure to provide complete information will delay intake process.

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax: _____

Primary Care Provider

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax: _____

Prosthetist

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax: _____

Physical Medicine and Rehab Physician/Physiatrist

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax: _____

Pain Medicine Specialist

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax: _____

Have you had any recent images of your residual limb in the past five years?

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XRs No Yes Facility: _____ Phone: _____ Fax: _____

CTs No Yes Facility: _____ Phone: _____ Fax: _____

MRIs No Yes Facility: _____ Phone: _____ Fax: _____

Thank you for your time spent completing this questionnaire. We have one last request. Please sign up for My Health Connection, <https://www.uhealth.org/access-my-health-connection/>. My Health Connection (MHC) allows our team to streamline communication and ensure your privacy. Our patients are from all over the world and we want to be able to provide immediate communication from anywhere. Our team takes a multidisciplinary approach to your healthcare and this requires a high degree of coordination. In MHC you will be able to view upcoming appointments, send our team messages, and share valuable post-operative photos.

Ways to Return Questionnaire

Phone: 1-844-800-(LIMB) 5462
Fax: 720-553-0402
limbrestoration@uhealth.org

Anschutz Outpatient Pavilion
1635 Aurora Court
Mail Stop F722
Aurora, Colorado 80045

Thank you again for your interest in our program. Once the above steps are complete please call, 1-844-800- (LIMB) 5462, and we will schedule one on one time to review your history and discuss next steps. We look forward to hearing from you!

Sincerely,



Jason W. Stoneback, MD Director, Limb Restoration Program University of Colorado Hospital
Department of Orthopedics

University of Colorado School of Medicine 1-844-800-LIMB (5462)