Engelbrecht PHYSIO INC. EST 1996

DOCTOR'S RISK SCREENING ASSESSMENT FOR PARTICIPATION IN CHRONIC MSK REHABILITATION PROGRAM

Patient name & surname:

Patient ID/passport number:

Date of birth:

Medical aid:

Medical aid plan:

Medical aid number:

Date of assessment:

MEDICAL HISTORY

Onset of illness/injury/symptoms date:

Onset & history of illness/injury/symptoms details:

Is the patient taking any medication for their current condition/injury?

☐ Yes ☐ No

If yes, please specify:

At the time of assessment, is future surgery/ intervention planned within the next 3 months?

☐ Yes ☐ No

If yes, please specify:

At the time of assessment has the patient undergone surgery/intervention within the last 3 months?

☐ Yes ☐ No

If yes, please indicate type of surgery/intervention:

Date of surgery/intervention:

Relevant past medical history (history of trauma/fracture/surgery):

Relevant family medical history:

CO-MORBID DIAGNOSIS & GENERAL HEALTH

Does the patient currently have, or have a history of, any of the following medical conditions?

☐ Yes ☐ No

If yes, please indicate the condition:

- ☐ Back and/or neck problems (whiplash/scoliosis/extra vertebrae)
- ☐ Epilepsy
- ☐ Excessive bleeding after extractions, injury or surgical operations
- ☐ Gastric conditions *(hernias/diarrhoea/other)*
- ☐ Heart conditions *(e.g. angina/congenital diseases/pacemaker/ rheumatic fever/ other)*
- ☐ High BP
- ☐ High cholesterol

CO-MORBID DIAGNOSIS & GENERAL HEALTH

- [ ] History of thrombosis *(varicose veins/ circulatory problems etc.)*
- [ ] Kidney or bladder disease
- [ ] Liver condition *(jaundice/hepatitis/other)*
- [ ] Low BP
- [ ] Malignant disease *(cancer)*
- [ ] Osteoporosis or other disease of the bones and joints
- [ ] Over- or under-active thyroid
- [ ] Pregnant
- [ ] Respiratory conditions *(asthma/TB/ Bronchitis/Other lung disease)*

Comments/differential diagnosis:

Is the patient taking medication for a chronic/ Co-morbid condition?

- [ ] Yes
- [ ] No

If yes, please specify:

PHYSICAL ASSESSMENT

Reported symptoms *(comment on patients reported pain, how they describe their symptoms etc.):*

Physical assessment details *(consider range of movement, muscle strength, general observations, special tests etc.):*

RED FLAGS

Does the patient present with red flags?

- [ ] Yes
- [ ] No

If yes, please indicate what has been identified:

- [ ] Thoracic pain
- [ ] Age of onset less than 20 or more than 55 years
- [ ] Loss of control of bowel or bladder
- [ ] Severe or progressive sensory alteration or weakness in lower limbs (foot drop or disturbed gait)
- [ ] High fever, chills or sudden weight loss
- [ ] Saddle anaesthesia (numbness in groin area) irrespective of body position
- [ ] History of immunosuppression
- [ ] Recently experienced a fall; slipped on a surface/fell from a height *(within the last 6 weeks)*
- [ ] Recently involved in an MVA *(within the last 6 weeks)*
- [ ] Vertebral artery insufficiency
- [ ] Long-term corticosteroid use
- [ ] Sudden severe back pain with abdominal pain
- [ ] History of cancer
- [ ] Structural deformity/instability
- [ ] Pain worsening at night
- [ ] Other _____

CONCLUSION

Is the patient medically safe to continue participating in the rehab program? [ ] Yes [ ] No

If no, please provide further information:

If the patient is not safe for the program, please indicate plan of action:

ASSESSING DOCTOR'S DETAILS

Name: _____

Email: _____

HPCSA no: _____

Practice no: _____

SIGNATURE

PRACTICE STAMP