

Assessment Form: Comfyprene Hand / Elbow Splints



Patient Name:	HICN #
Facility:	
Address:	
Primary Diagnosis:	Secondary Dx:

Prognosis:	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>
Mobility:	Ambulatory	<input type="checkbox"/>	Wheelchair Confined	<input type="checkbox"/>	Bed Confined	<input type="checkbox"/>
Communication:	Makes Needs Know	<input type="checkbox"/>	Unable to Make Needs Known	<input type="checkbox"/>		<input type="checkbox"/>
U.E. Sensation:	Intact	<input type="checkbox"/>	Moderately Impaired	<input type="checkbox"/>	Severely Impaired	<input type="checkbox"/>
U.E. Active ROM:	WNL	<input type="checkbox"/>	Mildly Restricted	<input type="checkbox"/>	Severely Restricted	<input type="checkbox"/>
U.E Passive ROM:	WNL	<input type="checkbox"/>	Mildly Restricted	<input type="checkbox"/>	Severely Restricted	<input type="checkbox"/>

Diagnosis	Rt	Lt	Comments
Wrist Drop	<input type="checkbox"/>	<input type="checkbox"/>	
Wrist Contracture	<input type="checkbox"/>	<input type="checkbox"/>	
MP Contracture	<input type="checkbox"/>	<input type="checkbox"/>	
Finger Joint Contracture	<input type="checkbox"/>	<input type="checkbox"/>	
Elbow Contracture	<input type="checkbox"/>	<input type="checkbox"/>	
Ulnar / Radial Deviation	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased Muscle Strength	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased ADL Function	<input type="checkbox"/>	<input type="checkbox"/>	
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Pressure Sores	<input type="checkbox"/>	<input type="checkbox"/>	
Hygiene Deficits	<input type="checkbox"/>	<input type="checkbox"/>	

Treatment Goals	
Prevent Fixed Contractures	<input type="checkbox"/>
Support Flaccid Hand, Wrist and Elbow	<input type="checkbox"/>
Manage Arthritic Joint Deformities	<input type="checkbox"/>
Decrease Pain	<input type="checkbox"/>
Increase U.E. Function	<input type="checkbox"/>
Control Ulnar or Radial Deviation	<input type="checkbox"/>
Improve Muscle Strength	<input type="checkbox"/>
Improve ADL Function	<input type="checkbox"/>
Increase Range of Motion	<input type="checkbox"/>
Decrease Pressure of Motion	<input type="checkbox"/>
Increase Hygiene	<input type="checkbox"/>

Treatment Plan:	
<input type="checkbox"/> Deviation Hand (DH-CP)	<input type="checkbox"/> Hand Separate Finger (HSF-CP)
<input type="checkbox"/> Dorsal Hand (DORSH-CP)	<input type="checkbox"/> Opposition Hand Thumb (OPH-CP)
<input type="checkbox"/> Hand Wrist Finger (H-CP)	<input type="checkbox"/> Elbow (E-CP)
<input type="checkbox"/> Hand Thumb (HT-CP)	<input type="checkbox"/> Elbow Goniometer (EG-CP)
<input type="checkbox"/> Hand Cock-Up (HC-CP)	<input type="checkbox"/> Elbow Spring Loaded Goniometer (ESG-CP)
<input type="checkbox"/> Hand Contour (HCO-CP)	<input type="checkbox"/>

Observe from 15 to 30 min. intervals. Then graduate to 1 to 2 hour intervals. Remove and check for pressure areas.

I certify active treatment of this patient. This equipment is part of my recommended treatment and is reasonable and medically necessary. The above information is true and accurate to the best of my knowledge.

Physicians Signature: _____ Date: _____

Address: _____

Contact No.: _____ UPIN # _____