

**Initial Assessment for Lower Limb Functional Electrical Stimulation**

Name..... DOB..... Address:	GP	Consultant	Referred by
	Receiving Physio/OT? Y / N		
Tel. No.	Details.....		

HISTORY OF PRESENT CONDITION AFFECTED SIDE L R BILATERAL

**Medical History**

Epilepsy Y / N Controlled Y / N  
 Fit Frequency: .....  
 Details.....

Cardiac arrhythmias Y / N Pacemaker Y / N  
 Other cardiac impairment Y / N  
 Details.....

Respiratory problems? Y/N  
 Details.....

Diabetes Y / N  
 Details .....

Skin Problems Y / N  
 Details .....

Sensation Problems Y / N  
 Details .....

Other ( e.g. orthopaedics)  
 .....

Falls:...Y/N.....Frequency...../Month/Week.....

Injury..... Hospital Y/N.....

**Drug History**

**Botulinum Toxin?**

**Social History**

Climbs stairs? Y / N

Lives with/ family .....

Assistance with ADLs? .....

Works? .....

Drives? .....

Usual distance walked .....

Patient's perception of main problem;

Wheelchair user Y/N

**Clinician** (sign, print name and designation, date)

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<b>Lower Limb Assessment Range of Movement</b>	Patient Name.....
	DOB/ NHS No.....

Position of Assessment .....	Passive ROM		MRC Scale		Ashworth Scale			
Hip	L	R	L	R	Hip	L	R	
Flexion					Flexors			
Extension					Extensors			
Abduction					Abduction			
Adduction					Adduction			
Knee	L	R	L	R	Knee	L	R	
Flexion					Flexors			
Extension					Extensors			
Ankle	L	R	L	R	Ankle	L	R	
Plantarflexion					Plantarflexors			
Dorsiflexion					Dorsiflexors			
Eversion					Evertors			
Inversion					Invertors			
Clonus	Right	0	1	2	Left	0	1	2
		0 = none	1 = moderate			2 = severe		

**Gait Analysis**

**10m WALKING TESTS (if using AFO only)**

<b>WALK 1 (with AFO)</b>	Time:	Speed:	Borg RPE:
<b>WALK 2 (with AFO)</b>	Time:	Speed:	Borg RPE:

**Clinician** (sign, print name and designation, date)

**Initial Assessment for Lower Limb Functional Electrical Stimulation**

**Lower Limb Assessment  
GAIT**

Patient Name.....  
DOB/ NHS No.....

Use of an aid: Y / N (Description).....

Use of orthosis (circle)      Using AFO                      Never used AFO                      Rejected AFO

Other orthosis .....

Reason for discarding orthosis  
.....

Observed to be independent in transfers and gait necessary for treatment? Y /N  
*(If no please complete manual handling form )*

Problem List	Tick Box	Treatment
		Stimulator
Unilateral Dropped Foot		ODFS Pace
Bilateral Dropped Foot		O2CHS
Calf Resistance Cause.....		MS2 or ODFS Pace
Other Exercise Cause.....		MS2 or ODFS Pace

**Suggested Set Up Parameters**

Output level .....

Ramps.....

Electrode positions.....

Other e.g. triggering .....

**Clinician** (sign, print name and designation, date)