

Clinical Care Pathway; O2CHS

Patient Details Front Sheet

Name..... DOB.....	Address (Attach label if available)
Contact telephone numbers; Home..... Work..... Mobile.....	Emergency contact details; Name..... Contact number..... Relationship to patient.....
<u>GP details</u> Name; Telephone number;	Referring doctor? Y N Practice address;
<u>Consultant details</u> Name; Telephone number (if known);	Referring doctor? Y N Address;
<u>Details of other professionals to be copied into correspondence</u>	
<u>Changes to medication (give dose where known) since Initial assessment</u>	
<u>Primary Diagnosis:</u> <u>Date of First Set-up</u> <u>Initial Outcome measures:</u> NS Speed: _____ NS Borg RPE: _____	



Odstock Medical Limited

National FES Centre
 Salisbury District Hospital
 Salisbury
 Wiltshire
 SP2 8BJ
 UK

Tel: +44 (0) 1722 429065
 Fax: 44 (0) 1722 425623
 Enquiries @odstockmedical.com
www.odstockmedical.com

Patient Contract

1. I agree that staff employed by the National Clinical FES Centre, Odstock Medical Ltd, Salisbury District Hospital, Salisbury, UK may provide me with FES treatment.

Patient/carer initial

2. I understand that my equipment remains the property of the FES Centre and I agree to return it when I am no longer receiving treatment from the FES Centre.

Patient/carer initial

3. Should I find that I am unable to attend an appointment, I agree to inform the FES centre at the earliest opportunity. I understand that should I fail to attend 2 or more appointments **without letting the FES Centre know**, I will be discharged and asked to return my equipment.

Patient/carer initial

4. I am aware that should I cancel and rearrange more than 2 appointments **without a valid reason agreed with my clinician**, I will be discharged and asked to return my equipment.

Patient/carer initial

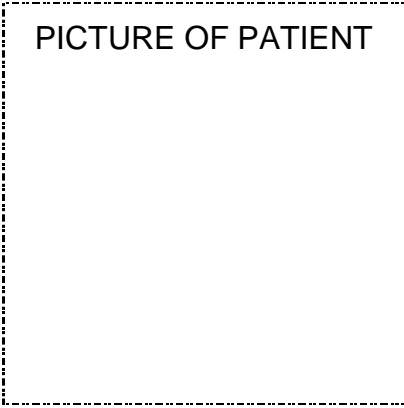
5. I understand that should I fail to return my equipment after being discharged I will be charged for its value.

Patient/carer initial

Patient/ carer sign**Print****Date**.....

Clinician sign.....**Print**.....**Date**.....

Equipment Type	O2 CHS	Other	Other
Serial Number			
Instructions Supplied			
Signature of User			
Signature of Clinician			
Date Equipment Returned			
Name and Signature (received by):			



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VIDEO and PHOTOGRAPHIC CONSENT FORM

In the course of your treatment at the National Clinical FES Centre it may be useful to use video or still photography to record your condition or performance. This may be for 3 reasons:

- 1. To record your present condition so a comparison can be made at a later date to monitor your progress.
- 2. To illustrate the type of treatment you are receiving for the purpose of teaching other clinicians.
- 3. To illustrate the type of treatment you are receiving for the purpose of promoting FES.

If the video or photograph can be taken without revealing your identity by showing your face, this will be done. However, this is not always possible and it may be that you might be recognisable. You do not have to give your permission to be videoed or photographed and refusal will not affect your treatment at Salisbury District Hospital in any way.

Please initial the items to which you give consent

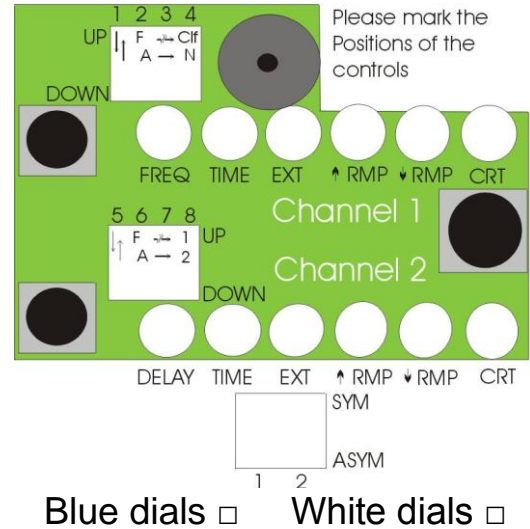
- 1. I confirm that I have read and understand the above and have had the opportunity to ask questions.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time,
without giving any reason, without my medical care or legal rights being affected
- 3. I understand that I may be recognisable from the video recording or photography
- 4. I give my permission for video recordings or photography to be used to monitor my treatment.
- 5. I give my permission to use video recordings or photography for educational purpose
- 6. I give my permission to use video recordings or photography for promotional purposes

Patient/carer sign.....Print.....Date.....

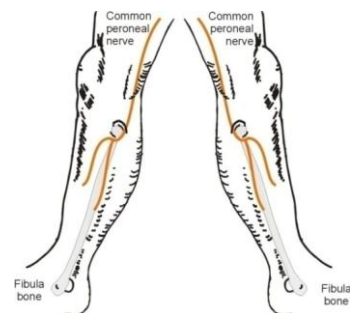
Clinician sign.....Print.....Date.....

O2CHS SET UP	Date:
Patient name.....	Clinician sign
DOB..... <i>(Attach label if available)</i>	Print name.....
	Designation.....

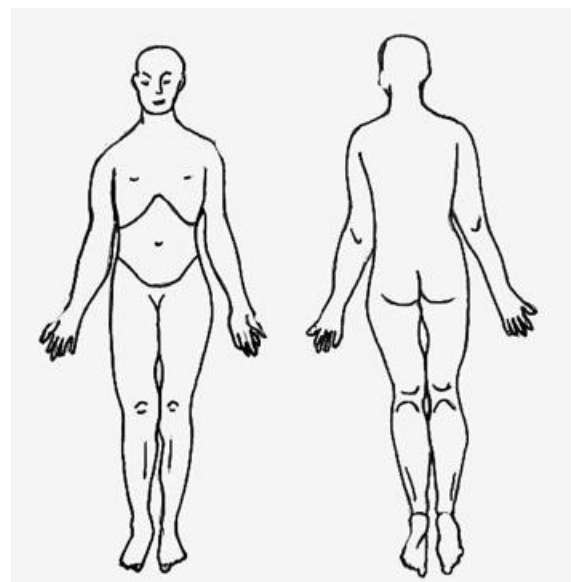
Treated side: Bilateral L R	Clinician Initial	Not required
Implied consent		
Changes to patient details recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
Skin care		
F/S positioning and insertion		
Written / photographic instructions issued		
Precautions given		
Skin checked on day 1		
Skin checked on day 2		
Skin irritation form completed		
Electrode positions found/recorded		
Stimulation parameters set/recorded		
Consent forms completed and COPY of contract given to pt		
Photo taken of pt		
GAS and VAS form completed		
10 metre walks completed		
Pt Handling Profile completed		



CHANNEL 1	
CHANNEL 2	



F/S position: _____



CONSUMABLES ISSUED		
Electrodes (no. + type)		
Blue Pals 50 x 50.....	Other.....	
Footswitch		
Electrode leads (length)		
Footswitch leads (length)		
Insoles (size + side)		
Accessories:	Urileeve	Linen bag

O2CHS SET UP	Date:
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Patient name..... DOB <i>(Attach label if available)</i>	Clinician sign Print name..... Designation.....
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10 METRE WALK	<i>(state reason if not completed)</i>
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	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (Ch1)			
Walk 4 (Ch1 and Ch 2)			
Walk 5 (no FES)			
Change with Channel 1 only (Orthotic effect)		%	Absolute value e.g. +/- 2
Change with Ch 1 and Ch 2 (Orthotic effect)		%	Absolute value e.g. +/- 2

Pt's perception of benefits using FES:

WALKING AID: _____ UNASSISTED:

O2CHS SET UP	Date:
Patient name..... DOB..... <i>(Attach label if available)</i>	Clinician sign Print name..... Designation.....

Goal Attainment Scale (GAS)

Much more than expected (+2)			
More than expected (+1)			
Most likely outcome (0)			
Less than expected outcome (-1) (START)			
Much less than expected (-2)			
<u>Timescale</u>			
<u>Sign, print and date:</u>			
<u>Review</u>			
<u>Date and level achieved</u>			

TOTAL GAS SCORE: _____ (use table)

- At the -1 level insert patient's current ability/symptom
- At the 0 level insert the most likely level of improvement
- At +1 and +2 write even further improvements and at -2 if things got worse
- Aim to set one functional goal with patient
- Use the Visual Analogue Scale to identify 2 other subjective symptoms you hope will improve with FES treatment
- Setting goals to be achieved at 18weeks is normally best

O2CHS SET UP	Date:
Patient name.....	Clinician sign
DOB..... (Attach label if available)	Print name.....
	Designation.....

Visual Analogue Scale (VAS)

Use a blank Visual Analogue Scale when asking patients to rate their symptoms.

When recording here circle number, state with or without FES and date

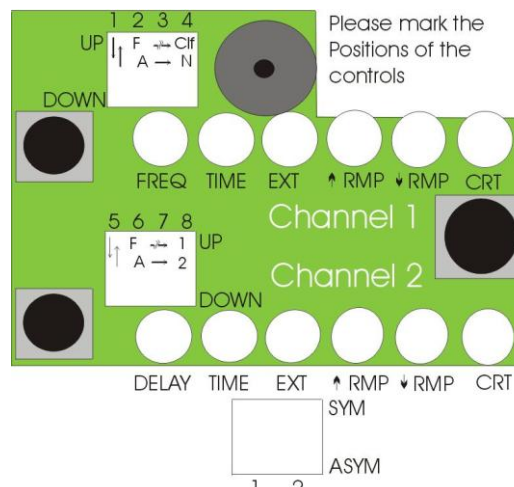
		<u>Highest quality of life</u>	<u>Highest fear of falling</u>
10	10	10	10
9	9	9	9
8	8	8	8
7	7	7	7
6	6	6	6
5	5	5	5
4	4	4	4
3	3	3	3
2	2	2	2
1	1	1	1
0	0	0	0
		<u>Lowest quality of life</u>	<u>No fear of falling</u>

At beginning of treatment: Select a couple of subjective symptoms and use the Visual Analogue Scale to rate their perception of those symptoms WITHOUT FES. e.g confidence walking, muscle tightness, pain, frequency of trips/falls. ALSO ask them to rate the 2 set measures of quality of life and fear of falling.

At follow-up appointments ask them how they rate these symptoms WITH FES (do not tell them what they scored at the beginning of treatment WITHOUT FES).

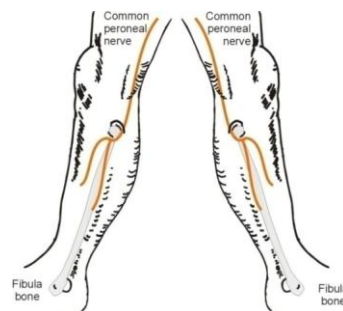
O2CHS	Treatment stage:	Date:
Patient name.....		Clinician sign
DOB..... <i>(Attach label if available)</i>		Print name.....
		Designation.....

Treated side: Bilateral L R	Clinician Initial	Not required
Implied consent		
Changes to patient details recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
Skin care		
Leads checked		
F/S positioning and insertion		
Written / photographic instructions issued		
Precautions given		
Skin checked		
Skin irritation form completed		
Electrode positions found/recorded		
Stimulation parameters set/recorded		
VAS discussed		
10 metre walks completed		
Patient Handling Profile completed		

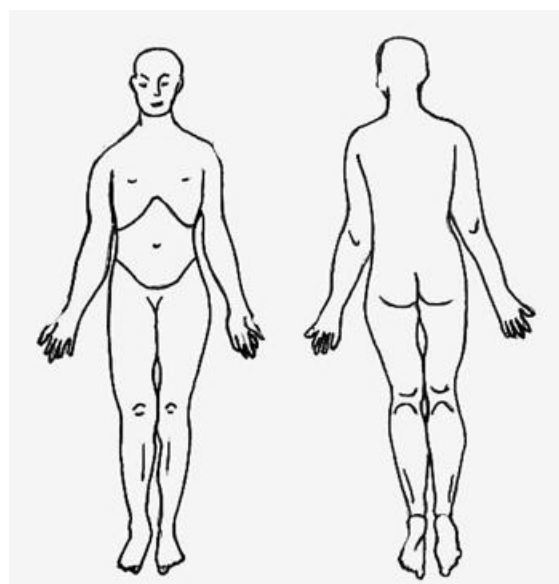


Blue dials White dials

CHANNEL 1	
CHANNEL 2	



F/S position: _____



CONSUMABLES ISSUED	
Electrodes (no. + type)	
Blue Pals 50 x 50.....	Other.....
Footswitch	
Electrode leads (length)	
Footswitch leads (length)	
Insoles (size + side)	
Accessories:	Urileeve Linen bag

O2CHS	Treatment stage:	Date:
--------------	-------------------------	--------------

Patient name..... DOB..... (Attach label if available)	Clinician sign Print name..... Designation.....
--	---

10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
Walk 1 (no FES)			
Walk 2 (no FES)			
Walk 3 (Ch1.....)			
Walk 4 (Ch1 and Ch 2)			
Walk 5 (no FES)			

Change with Channel 1 only (Orthotic effect)	%	Absolute value e.g. +/- 2
Change with Ch 1 and Ch 2 (Orthotic effect)	%	Absolute value e.g. +/- 2
Change since 1 st assessment (NS)	%	Absolute value e.g. +/- 2

Pt's perception of benefits using FES:	
VAS scores: <i>e.g. confidence in walking</i> $\frac{x}{10}$ no FES, $\frac{y}{10}$ with FES	
Frequency of FES use:	

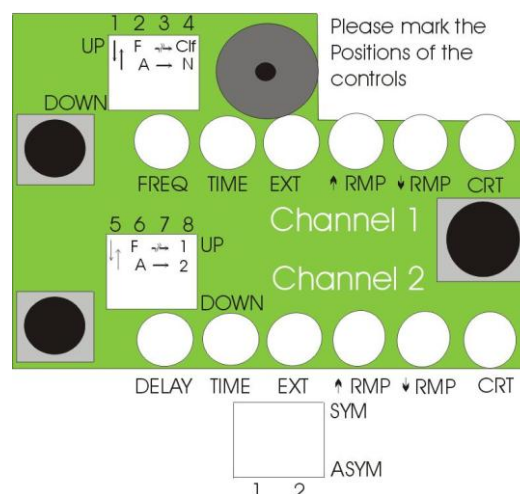
WALKING AID: _____ UNAIDED:

Standard VAS: Quality of life: .../10

Fear of falling: .../10
(Both to be quoted *with* FES)

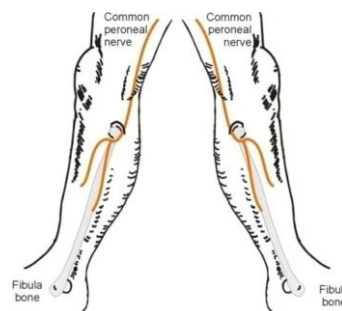
O2CHS	Treatment stage:	Date:
Patient name.....		Clinician sign
DOB..... (Attach label if available)		Print name.....
		Designation.....

Treated side: Bilateral L R	Clinician Initial	Not required
Implied consent		
Changes to patient details recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
Skin care		
Leads checked		
F/S positioning and insertion		
Written / photographic instructions issued		
Precautions given		
Skin checked		
Skin irritation form completed		
Electrode positions found/recorded		
Stimulation parameters set/recorded		
GAS and VAS form completed		
10 metre walks completed		
Patient Handling Profile completed		

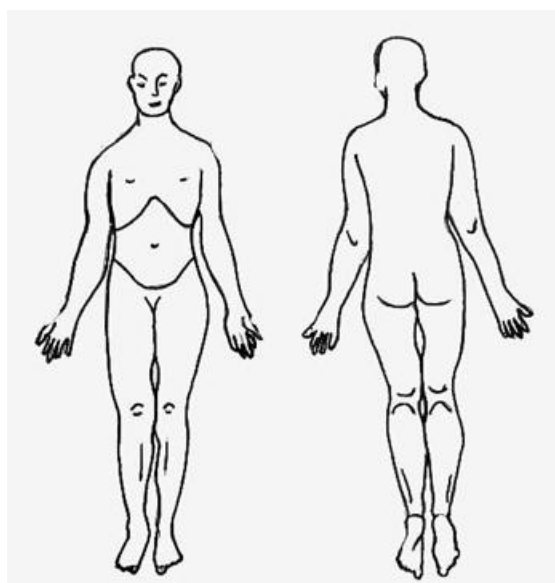


Blue dials White dials

CHANNEL 1	
CHANNEL 2	



F/S position: _____



CONSUMABLES ISSUED	
Electrodes (no. + type)	
Blue Pals 50 x 50.....	Other.....
Footswitch	
Electrode leads (length)	
Footswitch leads (length)	
Insoles (size + side)	
Accessories: Urileeve	Linen bag

O2CHS | **Treatment stage:** _____ **Date:** _____

Patient name..... DOB (Attach label if available)	Clinician sign Print name..... Designation.....
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10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (Ch1.....)			
Walk 4 (Ch1 and Ch 2)			
Walk 5 (no FES)			
Change with Channel 1 only (Orthotic effect)		%	Absolute value e.g. +/- 2
Change with Ch 1 and Ch 2 (Orthotic effect)		%	Absolute value e.g. +/- 2
Change since 1 st assessment (NS)		%	Absolute value e.g. +/- 2

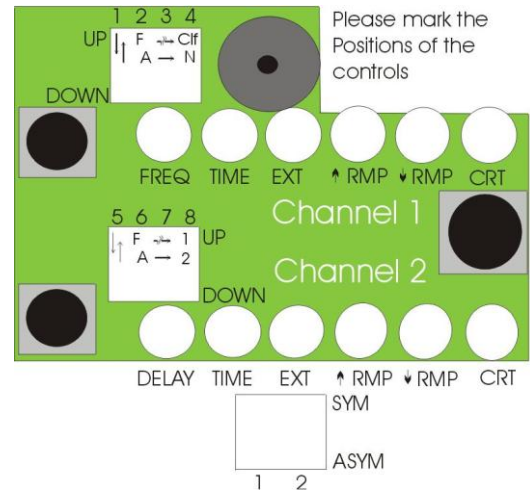
Pt's perception of benefits using FES:	
VAS scores: e.g. confidence in walking $\frac{x}{10}$ no FES, $\frac{y}{10}$ with FES	
Frequency of FES use:	

WALKING AID: _____ UNASSISTED:
Standard VAS: Quality of life:/10
 Fear of falling:/10
 (Both to be quoted *with* FES)

REMEMBER GAS form ^{18/}52

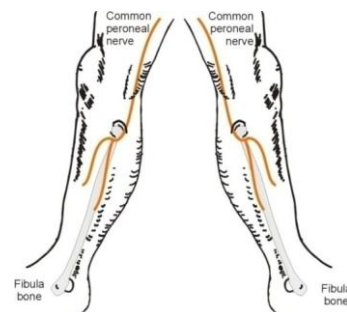
O2CHS	Treatment stage:	Date:
Patient name.....		Clinician sign
DOB		Print name.....
(Attach label if available)		Designation.....

Treated side:	Clinician	Not
Bilateral L R	Initial	required
Implied consent		
Changes to patient details recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
Skin care		
Leads checked		
F/S positioning and insertion		
Written / photographic instructions issued		
Precautions given		
Skin checked		
Skin irritation form completed		
Electrode positions found/recorded		
Stimulation parameters set/recorded		
VAS discussed		
10 metre walks completed		
Patient Handling Profile completed		

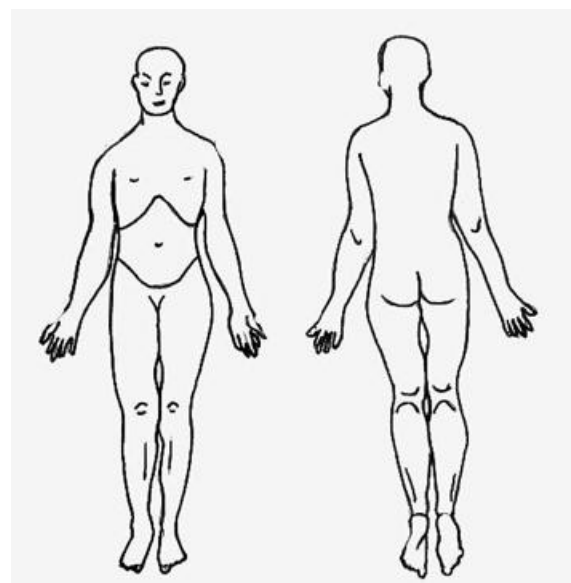


Blue dials White dials

CHANNEL 1	
CHANNEL 2	



F/S position: _____



CONSUMABLES ISSUED	
Electrodes (no. + type)	
Blue Pals 50 x 50.....	Other.....
Footswitch	
Electrode leads (length)	
Footswitch leads (length)	
Insoles (size + side)	
Accessories:	Urisleeve Linen bag

O2CHS	Treatment stage:	Date:
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Patient name..... DOB (Attach label if available)	Clinician sign Print name..... Designation.....
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10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
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Walk 2 (no FES)			
Walk 3 (Ch1.....)			
Walk 4 (Ch1 and Ch 2)			
Walk 5 (no FES)			

Change with Channel 1 only (Orthotic effect)	%	Absolute value e.g. +/- 2
Change with Ch 1 and Ch 2 (Orthotic effect)	%	Absolute value e.g. +/- 2
Change since 1 st assessment (NS)	%	Absolute value e.g. +/- 2

Pt's perception of benefits using FES:	
VAS scores: <i>e.g. confidence in walking</i> <i>1/10 no FES, 10/10 with FES</i>	
Frequency of FES use:	

WALKING AID: _____ UNASSISTED:

Standard VAS: Quality of life:/10
 Fear of falling:/10
 (Both to be quoted *with* FES)

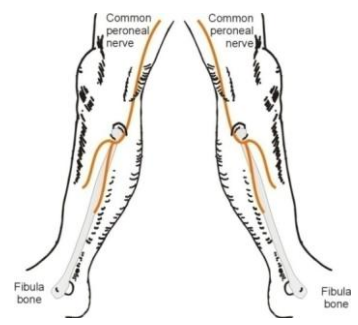
O2CHS Treatment stage:	Date:
Patient name.....	Clinician sign
DOB	Print name.....
<i>(Attach label if available)</i>	Designation.....

Treated side: Bilateral L R	Clinician Initial	Not required
Implied consent		
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Test procedure		
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Skin care		
Leads checked		
F/S positioning and insertion		
Written / photographic instructions issued		
Precautions given		
Skin checked		
Skin irritation form completed		
Electrode positions found/recorded		
Stimulation parameters set/recorded		
VAS discussed		
10 metre walks completed		
Patient Handling Profile completed		

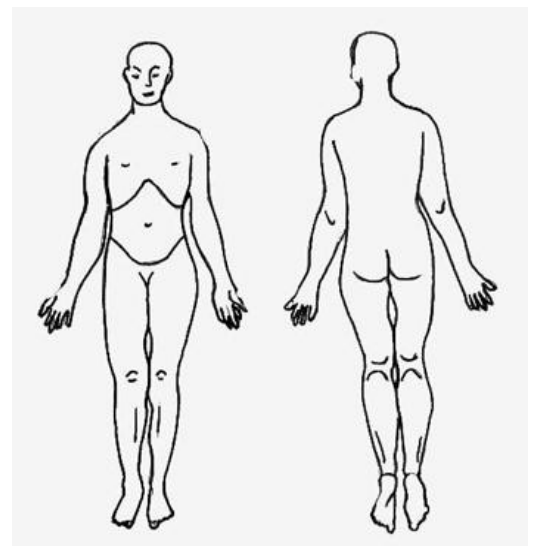
Please mark the Positions of the controls

Blue dials White dials

CHANNEL 1	
CHANNEL 2	



F/S position: _____



CONSUMABLES ISSUED		
Electrodes (no. + type)		
Blue Pals 50 x 50.....	Other.....	
Footswitch		
Electrode leads (length)		
Footswitch leads (length)		
Insoles (size + side)		
Accessories:	Urileeve	Linen bag

O2CHS	Treatment stage:	Date:
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Patient name..... DOB (Attach label if available)	Clinician sign Print name..... Designation.....
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10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
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Walk 2 (no FES)			
Walk 3 (Ch1.....)			
Walk 4 (Ch1 and Ch 2)			
Walk 5 (no FES)			

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Change since 1 st assessment (NS)	%	Absolute value e.g. +/- 2

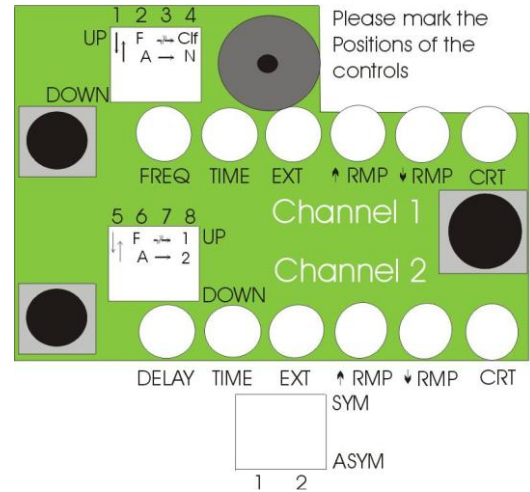
Pt's perception of benefits using FES:	
VAS scores: <i>e.g. confidence in walking</i> $\frac{x}{10}$ no FES, $\frac{y}{10}$ with FES	
Frequency of FES use:	

WALKING AID: _____ UNAIDED:

Standard VAS: Quality of life:/10
 Fear of falling:/10
 (Both to be quoted *with* FES)

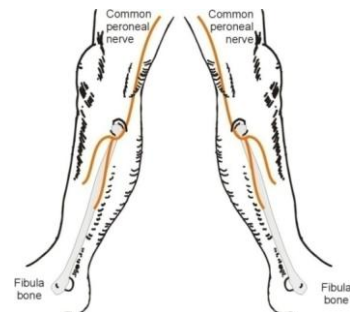
O2CHS	Treatment stage:	Date:
Patient name.....		Clinician sign
DOB		Print name.....
<i>(Attach label if available)</i>		Designation.....

Treated side: Bilateral L R	Clinician Initial	Not required
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Skin care		
Leads checked		
F/S positioning and insertion		
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Precautions given		
Skin checked		
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Stimulation parameters set/recorded		
VAS discussed		
10 metre walks completed		
Patient Handling Profile completed		

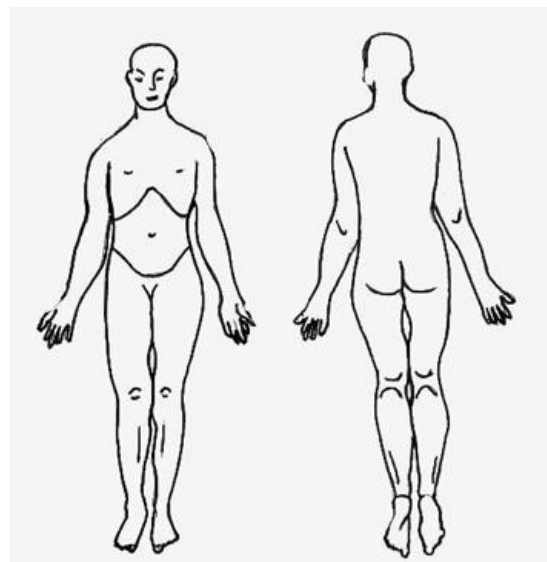


Blue dials White dials

CHANNEL 1	
CHANNEL 2	



F/S position: _____



CONSUMABLES ISSUED	
Electrodes (no. + type)	
Blue Pals 50 x 50.....	Other.....
Footswitch	
Electrode leads (length)	
Footswitch leads (length)	
Insoles (size + side)	
Accessories:	Urisleave Linen bag

O2CHS	Treatment stage:	Date:
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Patient name..... DOB (Attach label if available)	Clinician sign Print name..... Designation.....
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10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
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Walk 2 (no FES)			
Walk 3 (Ch1.....)			
Walk 4 (Ch1 and Ch 2)			
Walk 5 (no FES)			

Change with Channel 1 only (Orthotic effect)	%	Absolute value e.g. +/- 2
Change with Ch 1 and Ch 2 (Orthotic effect)	%	Absolute value e.g. +/- 2
Change since 1 st assessment (NS)	%	Absolute value e.g. +/- 2

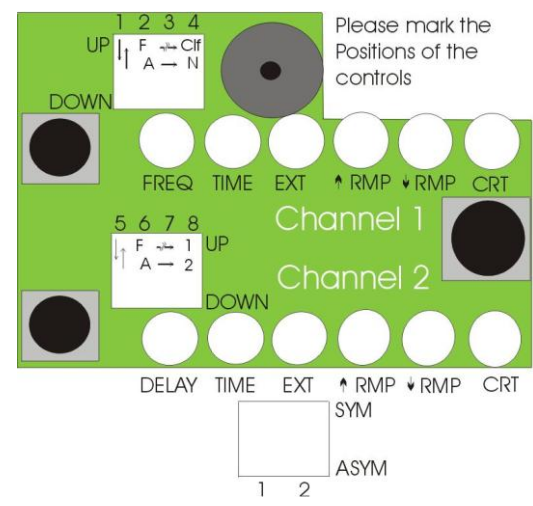
Pt's perception of benefits using FES:	
VAS scores: <i>e.g. confidence in walking</i> <i>1/10 no FES, 9/10 with FES</i>	
Frequency of FES use:	

WALKING AID: _____ UNAIDED:

Standard VAS: Quality of life:/10
 Fear of falling:/10
 (Both to be quoted *with* FES)

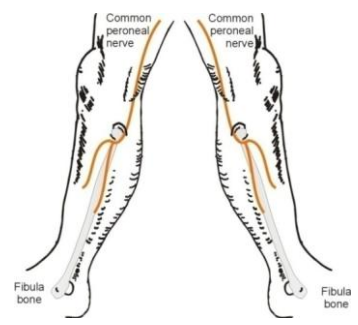
O2CHS	Treatment stage:	Date:
Patient name.....		Clinician sign
DOB		Print name.....
<i>(Attach label if available)</i>		Designation.....

Treated side:	Clinician	Not
Bilateral L R	Initial	required
Implied consent		
Changes to patient details recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
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F/S positioning and insertion		
Written / photographic instructions issued		
Precautions given		
Skin checked		
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Electrode positions found/recorded		
Stimulation parameters set/recorded		
VAS discussed		
10 metre walks completed		
Patient Handling Profile completed		

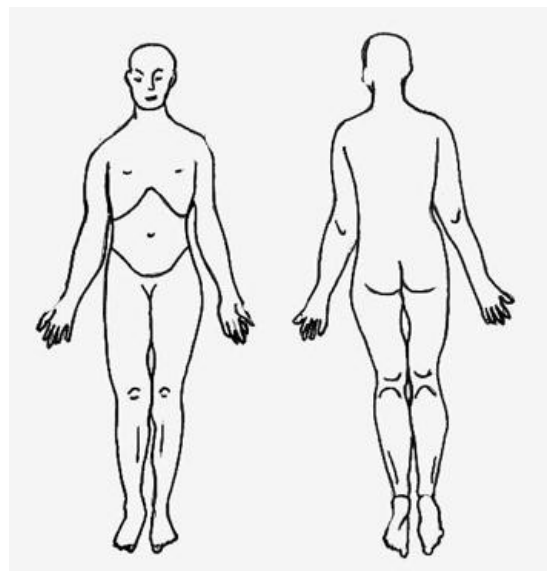


Blue dials White dials

CHANNEL 1	
CHANNEL 2	



F/S position: _____



CONSUMABLES ISSUED	
Electrodes (no. + type)	
Blue Pals 50 x 50.....	Other.....
Footswitch	
Electrode leads (length)	
Footswitch leads (length)	
Insoles (size + side)	
Accessories:	Urileeve Linen bag

O2CHS	Treatment stage:	Date:
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Patient name..... DOB (Attach label if available)	Clinician sign Print name..... Designation.....
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10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (Ch1.....)			
Walk 4 (Ch1 and Ch 2)			
Walk 5 (no FES)			

Change with Channel 1 only (Orthotic effect)	%	Absolute value e.g. +/- 2
Change with Ch 1 and Ch 2 (Orthotic effect)	%	Absolute value e.g. +/- 2
Change since 1 st assessment (NS)	%	Absolute value e.g. +/- 2

Pt's perception of benefits using FES:	
VAS scores: <i>e.g. confidence in walking</i> <i>1/10 no FES, 9/10 with FES</i>	
Frequency of FES use:	

WALKING AID: _____ UNASSAIDED:

Standard VAS: Quality of life:/10
 Fear of falling:/10
 (Both to be quoted *with* FES)

Patient Handling Profile

<u>Patient's name</u>		<u>DOB</u>	
<u>Handling Considerations</u>		Mental status/comprehension:.....	
Height:.....		Pain:.....	
Weight:.....		Motor deficit:.....	
Eyesight:.....		Skin integrity:.....	
Hearing:.....		Falls history:.....	
<u>Transfer</u>	Independent	<u>Requires Assistance</u>	<u>Additional Aids</u>
Sitting to standing	<input type="checkbox"/>	Handling belt plus 1 person	<input type="checkbox"/>
		Handling belt plus 2 people	<input type="checkbox"/>
Bed/chair to chair	<input type="checkbox"/>	Handling belt plus 1 person, step around	<input type="checkbox"/>
		Handling belt plus 2 people, step around	<input type="checkbox"/>
		Hoist	<input type="checkbox"/>
Walking	<input type="checkbox"/>	Handling belt plus one person	<input type="checkbox"/>
		Handling belt plus 2 people	<input type="checkbox"/>
Name..... Signature.....			
Designation..... Date of assessment.....			

Patient Handling Profile Amendments

Patient's name

DOB

Date of amendment	Task amended	Reason for change	New recommendation	Name / signature / designation

Discharge Summary
O2 CHS

Name: _____ DOB: _____ Date: _____

1. When was the use of the stimulator discontinued? _____

2. Why was treatment stopped?
Please put crosses by **any** response that was relevant.
Please **ring** the most important reason.
 - a. The stimulator did not help the users walking.
 - b. The equipment was unreliable.
 - c. Problems with skin allergy to the electrodes.
 - d. Problems finding the correct electrode positions.
 - e. The equipment was too difficult to use.
 - f. The equipment was too much bother to use.
 - g. The equipment was cosmetically unacceptable.
 - h. The user's mobility improved so they no longer needed the stimulator.
 - i. The user's mobility deteriorated so was no longer able to use the stimulator.
 - j. The stimulation was too painful.
 - k. The stimulator caused an increase in spasticity.
 - l. Autonomic dysreflexia
 - m. Death. Cause: _____
 - n. Lost to follow up
 - o. Unrelated medical complication. Please specify. _____
 - p. Other reasons, please specify. _____
 - q. Discharged to a local clinic, please specify. _____

3. Equipment returned? Y / N Discharged? Y / N

Clinician sign..... Print..... Designation.....

Continuation Sheet

Patient name:.....

DOB:.....

Clinician sign, print and date for each entry

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