

Clinical Care Pathway; ODFS

Patient Details Front Sheet

Name..... DOB/ PID	Address <i>(Attach label if available)</i>						
Contact telephone numbers; Home..... Work..... Mobile.....	Emergency contact details; Name..... Contact number..... Relationship to patient.....						
<table style="width:100%; border:none;"> <tr> <td style="border:none;"><u>GP details</u></td> <td style="border:none; text-align:right;">Referring doctor? Y N</td> </tr> <tr> <td style="border:none;">Name;</td> <td style="border:none;">Practice address;</td> </tr> <tr> <td style="border:none;">Telephone number;</td> <td></td> </tr> </table>		<u>GP details</u>	Referring doctor? Y N	Name;	Practice address;	Telephone number;	
<u>GP details</u>	Referring doctor? Y N						
Name;	Practice address;						
Telephone number;							
<table style="width:100%; border:none;"> <tr> <td style="border:none;"><u>Consultant details</u></td> <td style="border:none; text-align:right;">Referring doctor? Y N</td> </tr> <tr> <td style="border:none;">Name;</td> <td style="border:none;">Address;</td> </tr> <tr> <td style="border:none;">Telephone number (if known);</td> <td></td> </tr> </table>		<u>Consultant details</u>	Referring doctor? Y N	Name;	Address;	Telephone number (if known);	
<u>Consultant details</u>	Referring doctor? Y N						
Name;	Address;						
Telephone number (if known);							
<u>Details of other professionals to be copied into correspondence</u>							
<u>Current medication (give dose where known)</u>							



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www.odstockmedical.com

PATIENT CONTRACT

Date.....

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

Clinician sign.....

Print.....



LEADING REHABILITATION
THROUGH TECHNOLOGY

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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 purposes.
6. I give my permission to use video recordings or photography for promotional purposes.

Patient sign..... Print.....Date.....

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

ODFS Care Pathway ; set up

Date

Patient name.....

DOB/ PID

(Attach label if available)

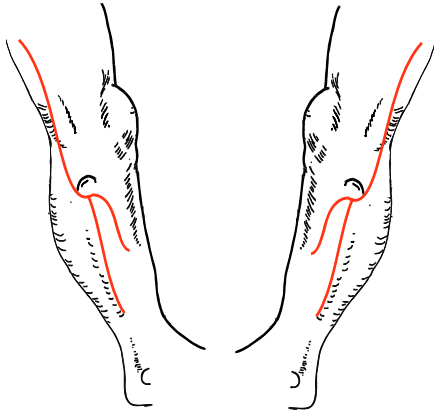
Clinician sign

Print name.....

Designation.....

	Treated side (circle)		L	R	Clinician Initial	Not required
1	Implied consent					
2.	Changes to patient details/ medication recorded on front sheet					
3	Patient/ carer education	Details if necessary			Clinician Initial	Not required
3a	Procedure for donning and doffing					
3b	Test procedure					
3c	Electrode positioning					
3d	Electrode care					
3e	Skin care					
3f	Footswitch positioning and insertion					
3g	Written / photographic instructions issued					
3h	Precautions given					
4a	Skin checked on day 1					
4b	Skin checked on day 2					
4c	Skin irritation form completed					
5	Electrode positions found / recorded					
6	Stimulation parameters set / recorded					
7	Technical information recorded					
8	Consent forms completed					
9	Problem list, treatment plan and goal sheet completed					
10.	10 metre walks completed					
11	Patient Handling Profile completed					
12	Consumables issued					
12a	Up to 3 packs of electrodes	Type:				
12b	Up to 2 footswitches	FSR position:				
12c	1 electrode lead	Length:				
12d	1 footswitch lead	Length:				
12e	Up to 2 insoles	Size:				

ODFS Care Pathway; set up	Date
Patient name.....	Clinician sign.....
DOB/PID..... <i>(Attach label if available)</i>	Print name.....
	Designation.....



5 8 10
2 mA

1 2
A B1 B2

0.5 1.5 2
0 s

0.5 1.5 2
0 s

0.5 1 2
0 s

2 4 6
0 s

Current x 10 Wave form Mode Falling edge ramp Rising edge ramp Extension Time

WAVE FORM	MODE
A. up - Sym Bi - phasic	B1. up - heel rise
A. down - Asym Bi - phasic	B1. down - heel strike
	B2. up - adaptive timing
	B2. down - fixed timing

MICROSTIM DETAILS	Serial number:

10 metre walk	Walking aid;			RHR	
	Time	HR	HR increase	Speed m/s	PCI
Walk 1 (no FES)					
Walk 2 (no FES)					
Walk 3 (with FES)					
Walk 4 (no FES)					
% Change with stimulation					
% Change since 1st assessment (NS)					

Additional Comments

ODSTOCK MEDICAL LTD EQUIPMENT RECEIPT FORM

THIS TABLE DETAILS THE EQUIPMENT THAT YOU HAVE BEEN GIVEN:

Name.....

DOB/ PID.....

Date.....

Equipment Type	ODFS Single Channel	O2CHS Two Channel	O4CHS Four Channel	MS2 Two Channel	[Other]*
Serial Number					
Instructions Supplied					
Signature of User					
Signature of Clinician					
Date Equipment Returned					
Name and Signature (received by):					

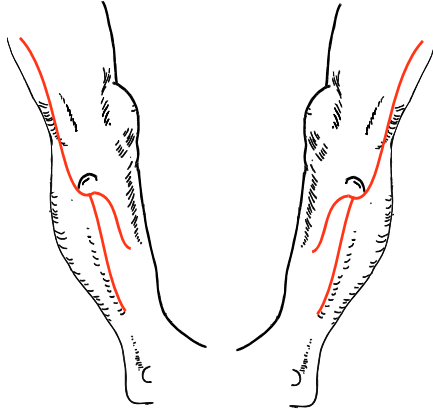
* Use this column for one off or custom made devices. They may not be CE marked but they will meet all Medical Device requirements.

Set-up; Problem list, treatment plan and goal sheet

Patient name..... DOB/PID..... (<i>Attach label if available</i>)		Clinician sign..... Print..... Date.....	
Date	Problem identified	Treatment plan	Clinician initial
	Unilateral foot drop	ODFS	
	Bilateral foot drop	02CHS	
	Increased calf tone limiting response to ODFS	MS2 V2	
		Other.....	
	Reduced ROM limiting response to ODFS	MS2 V2	
		Other.....	
	Lack of ankle stability on stance phase; uncontrolled by FES	ODFS + orthosis; type?.....	
	Hypersensitive to sensation of stimulation	MS2 V2	
Date set	Patient-specific objectives (in 18 weeks)	Outcome measure (where appropriate)	Date achieved
Date set	Objectives for long term use	Outcome measure (where appropriate)	

ODFS Care Pathway ; review			Date	
Patient name.....			Clinician sign	
DOB..... <i>(Attach label if available)</i>			Print name.....	
			Designation.....	
Treated side (circle) L R			Clinician Initial	Not required
1	Implied consent			
2.	Changes to patient details and medication recorded			
3	Patient/carer education- ODFS	Details if necessary	Clinician Initial	Not required
3a	Procedure for donning and doffing			
3b	Test procedure			
3c	Electrode positioning			
3d	Electrode care			
3e	Skin care			
3f	Fault finding			
3g	Written/photographic instructions issued			
4a	Skin checked			
4b	Skin irritation form completed			
5	Stimulation parameters reviewed and recorded			
6	Technical information recorded			
7	Patient videoed			
8	Problem list, treatment plan and goal sheet reviewed			
9	10 metre walks completed			
10	Patient Handling Profile completed			
11	Consumables issued			
11a.	Up to 3 packs of electrodes	Type:		
12b.	Up to 2 footswitches	FSR position:		
12c.	1 electrode lead	Length:		
12d.	1 footswitch lead	Length:		
12e.	Up to 2 insoles	Size:		

ODFS Care Pathway; review	Date
Patient name..... DOB..... (Attach label if available)	Clinician sign Print name Designation.....



<p>Current x 10</p>	<p>Wave form</p>	<p>Falling edge ramp</p>	<p>Rising edge ramp</p>	<p>Extension</p>	<p>Time</p>
<p>WAVE FORM</p> <p>A. up - Sym Bi - phasic A. down - Asym Bi - phasic</p>			<p>MODE</p> <p>B1. up - heel rise B1. down - heel strike B2. up - adaptive timing B2. down - fixed timing</p>		

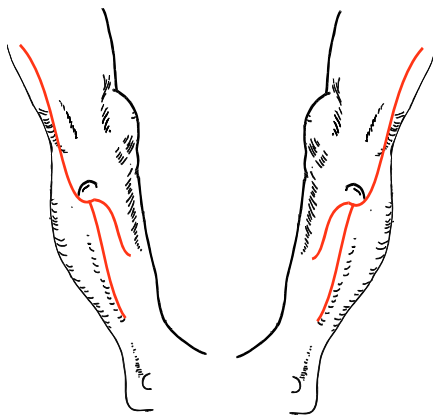
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% Change with stimulation					
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Additional Comments

ODFS Care Pathway ; review			Date	
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DOB.....			Print name.....	
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Patient name.....	Clinician sign.....
DOB.....	Print
(Attach label if available)	Designation.....



5 8 10
2 mA

Current x 10

1 2
A B1 B2

Wave form

0.5 1 1.5 2
0 s

Falling edge ramp

0.5 1 1.5 2
0 s

Rising edge ramp

5 1 2 4
1.5 5 6 s

Extension Time

WAVE FORM	MODE
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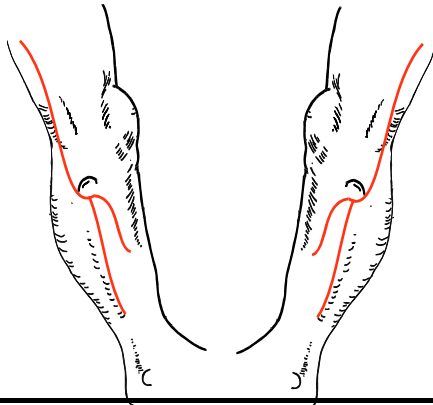
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Additional Comments

ODS Care Pathway; review		Date	Date	
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Patient name..... DOB..... <p style="text-align: center;"><i>(Attach label if available)</i></p>	Clinician sign Print name Designation.....
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5 2 8 10 mA Current x 10	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> </tr> <tr> <td style="text-align: center;">A</td> <td style="text-align: center;">B1 B2</td> </tr> </table> Wave Mode form	1	2	A	B1 B2	0.5 1 1.5 2 0 s Falling edge ramp	0.5 1 1.5 2 0 s Rising edge ramp	5 1 2 4 0 1.5 5 6 s Extension Time
1	2							
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WAVE FORM A. up - Sym Bi - phasic A. down - Asym Bi - phasic		MODE B1. up - heel rise B1. down - heel strike B2. up - adaptive timing B2. down - fixed timing						

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Walk 4 (no FES)					
% Change with stimulation					
% Change since 1st assessment (NS)					

Additional Comments

Patient Handling Profile

Patient details:						
<u>Name</u>		<u>DOB</u>		<u>PID</u>		
<u>Handling Considerations</u>						
<u>Height</u>		<u>Pain</u>				
<u>Weight</u>		<u>Motor Deficit</u>				
<u>Eyesight</u>		<u>Skin Integrity</u>				
<u>Hearing</u>		<u>Falls History</u>				
<u>Mental Status/ Comprehension</u>						
Transfer	Independent	Requires Assistance			Additional Aids	
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"/>				
Date of assessmentName.....Signature.....						
Designation.....						
Amendment/ Review date						

Signed.....

Printed.....

Designation..... Date.....

Discharge summary ODFS & O2CHS

Name: _____ 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 were 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..... <p style="text-align: center;"><i>(Attach label if available)</i></p>
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Clinician sign Print..... Designation..... Date.....

Versions	Changes	Author and date
2	Care pathway – combination of previous forms and extra detail	C.Jolley 22/11/07
	Date for review	January 2008

For FES Research information:

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LEADING REHABILITATION
THROUGH TECHNOLOGY

Barry Bull (Chairman) • Jon Lewis (CEO) • Malcom Cassells (Director) • Ian Swain (Director)

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