<u>ONGOING CLINICAL ASSESSMENT – UPPER LIMB NMES REVIEW</u>

Patient Name & DOB Date

1st Assessment/ follow up

Change in Manual Handling Status? Yes/No (if yes complete a M.H. form)

Skin Checked? Yes/ No Details…………………………………………………………

<u>PATIENT'S COMMENTS</u>

<u>CLINICIANS FINDINGS</u>

<u>OUTCOME OF TREATMENT SESSION</u>

Objectives reviewed? Yes/No details…………………………………………………………………...

Clinician …………………………… Print………………………….. Designation……………………

ONGOING CLINICAL ASSESSMENT – UPPER LIMB NMES REVIEW

Patient Name ……………………… **DOB……………….. Date………………………**

Functional/non-functional (please circle)

Agreed Treatment Goals

Outcome Measure(s) to be used

	Muscle activity stimulated	Electrodes	Mode	Stimulation level	Details/ positioning/ splints	Treatment duration	Treatment frequency
Treatment 1	Trapezius Supraspinatus Deltoid (anterior,middle,posterior) Triceps Biceps Forearm extensor Forearm flexors Lumbrical Thumb abduction Thenar eminence Other …………………………………………………………..						
Treatment 2	Trapezius Supraspinatus Deltoid (anterior,middle,posterior) Triceps Biceps Forearm extensor Forearm flexors Lumbrical Thumb abduction Thenar eminence Other …………………………………………………………..						
Treatment 3	Trapezius Supraspinatus Deltoid (anterior,middle,posterior) Triceps Biceps Forearm extensor Forearm flexors Lumbrical Thumb abduction Thenar eminence Other …………………………………………………………..						

4 Channel Stimulator

Channel 1	Channel 2	Channel 3	Channel 4	Setting A/B	Setting A/B	Frequency (Hz)	Pulse width (μs)	Period (s)	On time (s)	Ramp (s) channel 1&2	Ramp (s) channel 3&4

Clinician (sign, print name & date)………………………………………………………………………………………