

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.....
<p><u>GP details</u> Referring doctor? Y N</p> Name; Address; Telephone number;	
<p><u>Consultant details</u> Referring doctor? Y N</p> Name; Address; Telephone number (if known);	
<p><u>Details of other professionals to be copied into correspondence</u></p> 	
<p><u>Changes to medication (give dose where known) since Initial assessment</u></p> 	
<p><u>Primary Diagnosis:</u></p> <p><u>Date of First Set-up</u></p> <p><u>Initial Outcome measures:</u> NS Speed: _____ NS Borg RPE: _____</p>	



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	ODFS [®] Pace	Other	Other
Serial Number			
Instructions Supplied			
Signature of User			
Signature of Clinician			
Date Equipment Returned			
Name and Signature (received by):			



Odstock Medical Limited

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



Leading Rehabilitation
Through Technology

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

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.....

ODFS® Pace Set-up	Date
Patient name.....	Clinician sign
DOB	Print name.....
(Attach label if available)	Designation.....

Treated side:	L	R	Clinician Initial	Not required
Implied consent				
Changes to patient details/medication recorded on front sheet				
Procedure for donning and doffing				
Test procedure				
Electrode positioning				
Electrode care				
Skin care				
Footswitch 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 patient				
Photo taken of patient				
GAS and VAS form completed				
10 metre walks completed				
Patient Handling Profile completed				
CONSUMABLES ISSUED				
Electrodes (no. + type)				
Blue Pals 50 x 50 Other.....				
Footswitch				
Electrode leads (length)				
Footswitch leads (length)				
Insoles (size + side)				
Accessories: Pouch Leg strap				

Parameter	Setting
Set up	
Current	mA
R. Ramp	ms
Extn	ms
F. Ramp	ms
Time Out	ms
Delay	ms
Waveform	ASYM / SYM
Freq	Hz
Sounder	SETUP / OFF / ALWAYS
Beeps	ON ⁺ / ON / OFF
Timing	ADAPTIVE / FIXED / NTO
Lock	OFF / 1s / 3s
Exe	OFF / ON Time:
Exercise set up	R ON OFF
Steps	
No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Software	
Serial Number	

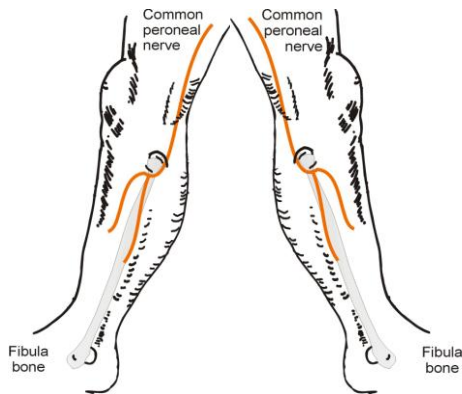
ODFS® Pace Set-up	Date
Patient name.....	Clinician sign
DOB..... (Attach label if available)	Print name.....
	Designation.....

10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (with FES)			
Walk 4 (no FES)			
Change with stimulation (Orthotic effect)		%	Numerical value e.g. +/- 2

Pt's perception of benefits using FES:

WALKING AID: _____ UNASSISTED:



F/S POSITION: _____

Goal Attainment Scale (GAS)

Patient name:	DOB:.....
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<u>DESCRIPTION:</u>	GOAL 1	GOAL 2	GOAL 3

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 18 weeks is normally best

Visual Analogue Scale (VAS)

Patient name:	DOB:.....
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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>High 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).

Patient name..... DOB/ PID <i>(Attach label if available)</i>	Clinician sign Print name..... Designation.....
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Treated side:	L	R	Clinician Initial	Not required
Implied consent				
Changes to patient details/medication recorded on front sheet				
Procedure for donning and doffing				
Test procedure				
Electrode positioning				
Electrode care				
Skin care				
Leads checked				
Footswitch 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				
CONSUMABLES ISSUED				
Electrodes (no. + type)				
Blue Pals 50 x 50 Other.....				
Footswitch				
Electrode leads (length)				
Footswitch leads (length)				
Insoles (size + side)				
Accessories: Pouch Leg strap				

Parameter	Setting
Set up	
Current	mA
R. Ramp	ms
Extn	ms
F. Ramp	ms
Time Out	ms
Delay	ms
Waveform	ASYM / SYM
Freq	Hz
Sounder	SETUP / OFF / ALWAYS
Beeps	ON ⁺ / ON / OFF
Timing	ADAPTIVE / FIXED / NTO
Lock	OFF / 1s / 3s
Exe	OFF / ON Time:
Exercise set up	R ON OFF
Steps	
No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Log reset today?	Y / N
Software version	<i>Updated?</i> <input type="checkbox"/>
Serial Number	<i>No change</i> <input type="checkbox"/>

Patient name.....

Clinician sign

DOB/ PID
(Attach label if available)

Print name.....

Designation.....

10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (with FES)			
Walk 4 (no FES)			
Change with stimulation today (Orthotic effect)		%	Numerical value e.g. +/- 2
Change since 1st assessment (NS) (Carry over)		%	Numerical value e.g. +/- 2

Pt's perception of benefits of FES:

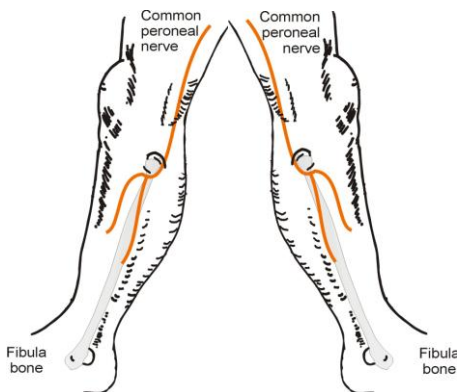
Patient-specific VAS scores: e.g. confidence in walking $\frac{x}{10}$ no FES, $\frac{y}{10}$ with FES

Frequency of FES use:

WALKING AID: _____ UNAIDED:

Standard VAS: Quality of life:/10

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



F/S POSITION: _____

ODFS® Pace	Treatment stage:	Date:
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Patient name..... DOB/ PID <i>(Attach label if available)</i>	Clinician sign Print name..... Designation.....
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Steps	
No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Log reset today?	Y / N
Software version	<i>Updated?</i> <input type="checkbox"/>
Serial Number	<i>No change</i> <input type="checkbox"/>

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

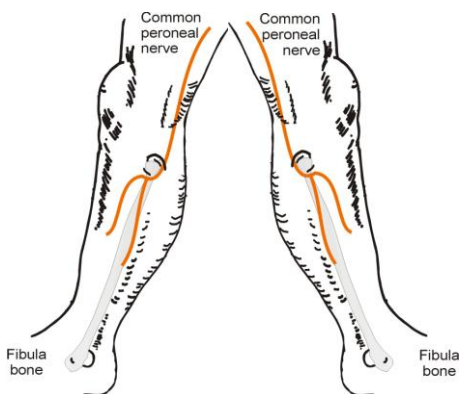
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Change with stimulation today (Orthotic effect)		%	Numerical value e.g. +/- 2
Change since 1st assessment (NS) (Carry over)		%	Numerical value e.g. +/- 2

Pt's perception of benefits of FES:	
Patient-specific 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)



F/S POSITION: _____

REMEMBER GAS form ^{18/}52

Patient name.....
 DOB/ PID
(Attach label if available)

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

Treated side:	L	R	Clinician Initial	Not required
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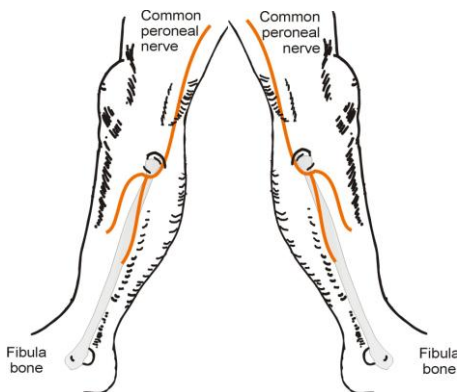
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Print name.....

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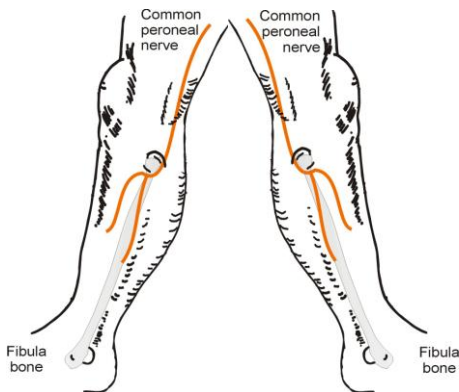
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Frequency of FES use:

WALKING AID: _____ UNAIDED:

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

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



F/S POSITION: _____

Patient name..... DOB/ PID <p style="text-align: center;"><i>(Attach label if available)</i></p>	Clinician sign Print name..... Designation.....
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Exe. Time	
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Serial Number	<i>No change</i> <input type="checkbox"/>

Patient name.....

Clinician sign

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(Attach label if available)

Print name.....

Designation.....

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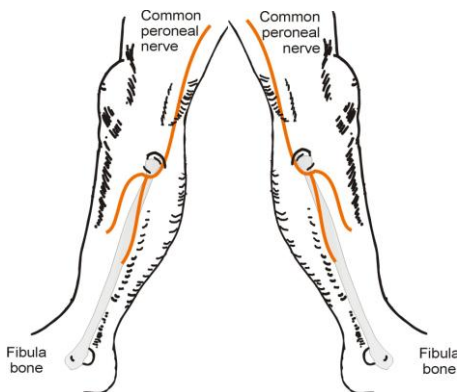
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Patient name..... DOB/ PID (Attach label if available)	Clinician sign Print name..... Designation.....
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Footswitch				
Electrode leads (length)				
Footswitch leads (length)				
Insoles (size + side)				
Accessories:				
	Pouch		Leg strap	

Parameter	Setting
Set up	
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Beeps	ON ⁺ / ON / OFF
Timing	ADAPTIVE / FIXED / NTO
Lock	OFF / 1s / 3s
Exe	OFF / ON Time:
Exercise set up	R ON OFF
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No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Log reset today?	Y / N
Software version	Updated? <input type="checkbox"/>
Serial Number	No change <input type="checkbox"/>

Patient name.....

Clinician sign

DOB/ PID
(Attach label if available)

Print name.....

Designation.....

10 METRE WALK (state reason if not completed)

	Time	Speed m/s	Borg RPE
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Walk 2 (no FES)			
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Change with stimulation today (Orthotic effect)		%	Numerical value e.g. +/- 2
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Pt's perception of benefits of FES:

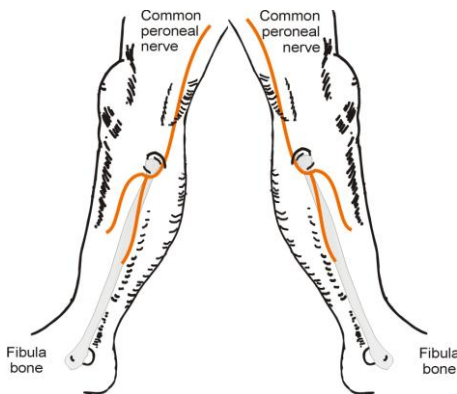
Patient-specific VAS scores: e.g. confidence in walking $\frac{x}{10}$ no FES, $\frac{y}{10}$ with FES

Frequency of FES use:

WALKING AID: _____ UNAIDED:

Standard VAS: Quality of life: /10

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



F/S POSITION: _____

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.....			

P.T.O. for amendments

Patient Handling Profile Amendments

Patient name.....	DOB
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Date of amendment	Task amended	Reason for change	New recommendation	Name / signature / designation

Discharge Summary
ODFS® Pace

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*

For FES Research information:

The National Clinical FES Centre
Salisbury District Hospital
Salisbury
Wiltshire SP2 8BJ
United Kingdom

Tel: +44 (0)1722 429065
Fax: +44 (0)1722 425263
Web: www.salisburyfes.com
Email: enquiries@salisburyfes.com

For FES devices and Clinical service:

Odstock Medical Ltd
Laing Building
Salisbury District Hospital
Salisbury
Wiltshire SP2 8BJ
United Kingdom

Tel: +44 (0)1722 429066
Fax: +44 (0)1722 425263
Web: www.odstockmedical.com
Email: enquiries@odstockmedical.com
sales@odstockmedical.com



Barry Bull (Chairman) • Malcolm Cassells (Director) • Philip Casson (CEO) • Ian Swain (Clinical Director)

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