DUNCAN FOUNDATiON

For more information visit:
www.duncanfoundation.org

Pre-Assessment Form
Post Polio Syndrome and Late Effects of Polio

FULL NAME:	DATE OF BIRTH:
PHONE NUMBER:	CURRENT HOME ADDRESS:
EMAIL ADDRESS:	THERAPIST:
REFERRAL SOURCE:	CURRENT GP:
NEXT OF KIN:	ACC/NHI NUMBER:

Questions about your Accommodation and Care Needs

WHAT IS YOUR OCCUPATION?

☐ Full Time ☐ Part Time ☐ Casual ☐ Retired ☐ Pension

AVOCATIONAL / LEISURE INTERESTS:

WHAT TYPE OF ACCOMMODATION DO YOU RESIDE IN:

☐ House/Unit ☐ Retirement ☐ Nursing Home ☐ Other

IF 'OTHER' WAS SELECTED, PLEASE DESCRIBE FURTHER:

DO YOU NEED HELP WITH YOUR PERSONAL CARE:

☐ No ☐ Yes

IF 'YES' WAS SELECTED, PLEASE DESCRIBE FURTHER:

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WHO HELPS YOU?

- [ ] Partner
- [ ] Family
- [ ] Community Services
- [ ] Residence Services

General Health and Activity

PLEASE TICK IF YOU HAVE ANY OF THE FOLLOWING:

- [ ] Heart Condition
- [ ] High Blood Pressure
- [ ] Pacemaker
- [ ] Low Blood Pressure
- [ ] Venous Condition
- [ ] Kidney Problems
- [ ] Chronic Lung Disease
- [ ] Asthma
- [ ] Osteoporosis
- [ ] Diabetes
- [ ] Cancer
- [ ] Infectious Disease
- [ ] Depression
- [ ] Anxiety
- [ ] Sleep Disturbance
- [ ] Metal Implants
- [ ] Visual Impairment
- [ ] Hearing Impairment
- [ ] Currently Smoking
- [ ] Fall (in the last 12 months)
- [ ] Hospitalised (in the last 12 months)
- [ ] Pain (Acute / Chronic)
- [ ] Neurological Condition

IF 'NEUROLOGICAL CONDITION' WAS SELECTED, PLEASE DESCRIBE FURTHER:

Patient: **Date:**

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Questions about Polio

How old were you when you were diagnosed with polio?
Where were you living at the time of diagnosis?

How did the polio effect your body?

Was there respiratory muscle involvement?
Was ventilation required?

Do you know how long you were paralysed for?
How long were you in hospital?

When you returned home were you still weak? If so, in what areas of your body?

After leaving hospital, did you receive physiotherapy and for how long?

Do you know how long, after getting polio could you walk?
Did you wear splints?

Did you require wheelchair use at any stage?

Patient: **Date:**

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What braces/devices did you use to walk with? How long were they used for?
Could you participate fully at school?

Did you have any reconstructive surgical procedures?
Do you have any other past medical history/co-morbidities that you think would be worth us knowing about?

Current Situation and Impairments

WHICH OF THESE SENTENCES BELOW BEST DESCRIBES YOUR PRESENT SITUATION:

- [ ] I am stable at present, but I am worried issues may arise.
- [ ] I have declining function but it is occurring slow.
- [ ] I have experienced a sudden or severe decline in function.

PLEASE DESCRIBE IN DETAIL THE FOLLOWING:

1. If you experienced a decline, when did you first notice it?
2. How many years do you think your condition was stable for?
3. What has changed in recent years?

Patient:

Date:

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Rivermead Mobility Index

Task	Score 1 = Yes 0 = No	Describe in Detail (Expand on aids / orthotics if required).
Turning Over in Bed: Do you turn from your back to your side without help?		
Lying to sitting: From lying in bed, do you get up to sit on the edge of your bed on your own?		
Sitting Balance: Can you sit on the edge of the bed without holding on for 10 seconds?		
Sitting to Standing: Can you stand up from any chair in less than 15 seconds and stand there for 15 seconds, using hands and/or an aid if necessary?		
Standing Unsupported: Can you stand for 10 seconds without any aid?		
Transfer: Do you manage to move from bed to chair and back without any help?		
Walking Inside: Can you walk 10 metres, with an aid if necessary, without standby help?		
Walking Inside: Can you walk 10 metres, with no aid/ caliper/splint (including walls/furniture) without standby help?		
Stairs: Can you manage a flight of stairs without help?		
Walking Outside: Can you walk outside, on even pavements, without help?		
Walking Outside: Can you walk outside over uneven ground (grass, gravel, snow, ice etc) without help?		
Picking up off floor: Can you manage to walk 5 metres, pick something up from the floor and then walk back without help?		

Patient:

Date:

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Bathing: Do you get into/out of the bath or shower and to wash yourself unsupervised and without help?		
Up and down 4 steps: Do you manage to go up and down four steps with no rail, but using an aid if necessary?		
Running: Can you run 10 metres without limping in four seconds (fast walk, not limping, is acceptable)?		

TICK WHAT WOULD YOU LIKE TO DISCUSS IN THE ASSESSMENT:

- ☐ My Pain
- ☐ My Fatigue Management
- ☐ Gain more education - self and family
- ☐ Advice on diet, nutrition and swallowing
- ☐ Help with sleep hygiene
- ☐ My Walking
- ☐ Tasks I am finding difficult

PLEASE DESCRIBE FURTHER:

HOW WOULD YOU RATE YOUR LIFE AT PRESENT?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Poor .... Excellent