Requisition for **Spasticity Assessment**

SPASTICITY
Assessment

Once completed, please fax or email to:

Dr. _____ at 204 - 787 - 1476 Email: _____

Patient name: _____ Birth date: _____

Health card #: _____ Phone #: _____

Address: _____

Choose one: ◯ Inpatient ◯ Outpatient ◯ Long-term care resident

Facility name: _____

Patient consent has been given for physiatrist/neurologist referral: ◯ Yes ◯ No

SDM (substitute decision maker) consent has been given: ◯ Yes ◯ No Phone #: _____

Lift or assistance required for patient transfer: ◯ Yes ◯ No

Diagnosis of spasticity due to (check one):

◯ Stroke ◯ Cerebral palsy ◯ Multiple sclerosis
◯ Spinal cord injury ◯ Traumatic brain injury ◯ Other: _____

Presentation of spasticity (check all that apply):

Muscle stiffness, tightness, or contraction in:

◯ Upper limb (shoulder, elbow, wrist, or hand) ◯ Right ◯ Left ◯ Both
◯ Lower limb (thigh, knee, ankle, or foot) ◯ Right ◯ Left ◯ Both
◯ Other: _____

Goals of therapy (check all that apply):

◯ Decrease pain ◯ Improve seating ◯ Prevention of pressure sores
◯ Improve transfers ◯ Improve gait pattern ◯ Prevention of contractures
◯ Aid in dressing ◯ Aid in hygiene ◯ Improve orthosis fit
◯ Other: _____

Important medical history/medications (HTN, A-Fib, anticoagulant, etc.):

☐ Medical report appended INR: ◯ Stable ◯ Unstable

Specify current medications, allergies, family history of disease, etc.:

Previous therapies tried: _____

Other comments:

For office use only:

Date: _____

Appointment date/time: _____

Referring physician: _____

Physician signature: _____ Date: _____

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