Appendix D: Assessment Form for Treating Physician

Patient Name:_____

Shoulder Injury or Illness Type: _____

Date of Injury, if any:_____

Mechanism of Injury (contact, non-contact, fall, motor vehicle accident, work-related, etc.):

_____

_____

_____

Are there any other related injuries (cervical, thoracic spine, elbow, wrist, tendon, soft tissue, etc.)?
Please describe:

_____

_____

Method of diagnosis (check all that apply):

- ❑ Clinical exam
- ❑ Imaging
- ❑ Operative findings

Pertinent diagnostic findings _____

_____

Treatment: ❑ Operative ❑ Non-operative
Description of treatment plan, including surgery dates:

_____

_____

_____

List of current medications related to injury:

_____

_____

_____

_____

Instability of shoulder on exam? ❑ Yes ❑ No

If "Yes," please describe_____

_____

Normal flexion/abduction strength? ❑ Yes ❑ No

Shoulder range of motion:

Flexion: _____ degrees
Abduction: _____ degrees
External Rotation: _____ degrees Internal Rotation: _____ degrees

Constant/Oxford/DASH Score, if available _____

WOSI Score, if available _____

Does your patient have any further therapy and/or treatment needs? ❑ Yes ❑ No

If "Yes," please describe type and expected duration of therapy and/or treatment needs:

_____

_____

If "No," is your patient at maximum medical improvement (MMI)? ❑ Yes ❑ No

Can your patient perform the following tasks?*:

Crawl under obstacles: ❑ Yes (unrestricted) ❑ Yes (with limitations) ❑ Unable to Perform

Climb a fence: ❑ Yes (unrestricted) ❑ Yes (with limitations) ❑ Unable to Perform

Climb a ladder: ❑ Yes (unrestricted) ❑ Yes (with limitations) ❑ Unable to Perform

Lifting, pushing or pulling with involved limb:

❑ Yes (unrestricted) ❑ Yes (with limitations) ❑ Unable to Perform

Grip and hold objects: ❑ Yes (unrestricted) ❑ Yes (with limitations) ❑ Unable to Perform

Do push-ups: ❑ Yes (unrestricted) ❑ Yes (with limitations) ❑ Unable to Perform

Do overhead work: ❑ Yes (unrestricted) ❑ Yes (with limitations) ❑ Unable to Perform

Does your patient have any other activity restrictions? ❑ Yes ❑ No

If "Yes," please describe restrictions and if these are permanent or temporary restrictions:

_____

_____

Provide additional information, not included above, that may be helpful to the police physician.

_____

_____

_____

_____

_____

_____

_____

_____

Signature of physician *Date*

_____ _____ _____

Printed name of physician *Phone number* *Fax number*