Requisition for **Spasticity Assessment**

Once completed, fax to: Physical Medicine and Rehabilitation
304 - 250 Keary Street, New Westminster, BC

Clinic contact: 604-544-5044 (Phone)
778-397-0058 (Fax)

Patient information

Name:	Birth date:	Phone:
Email:	Address:	City, Province:

Insurance information (if available)

PHN:	MSP:	
Primary insurance:	Policy number:	Member ID:
Secondary insurance:	Policy number:	Member ID:

Primary caregiver information ☐ Home ☐ Care facility Access to home care: ☐ Yes ☐ No ☐ n/a

Name:	Phone:	Email:

General Medical Information:

Date of spasticity diagnosis:

Diagnosis of spasticity due to: ☐ Stroke ☐ Cerebral Palsy ☐ SCI ☐ TBI ☐ MS ☐ Other:

Cognition:	☐ Cognitively intact	☐ Needs assistance	☐ Total care
Comorbidities:	☐ Infection ☐ Wound (pressure etc.) ☐ Other	Explain all that are checked:	
Current medications:	☐ Antibiotics	Other:	
Recent hospitalization:	☐ Yes ☐ No	Due to:	Date of release:
Recent falls:	☐ Yes ☐ No	Explain:	
Allergies:	☐ Yes ☐ No	If yes, specify:	

Functional Assessment Information:

Level of independence in daily living:			
Bathing:	☐ Independent	☐ Requires assistance	☐ Dependent
Dressing:	☐ Independent	☐ Requires assistance	☐ Dependent
Mobility:	☐ Independent	☐ Requires assistance	☐ Dependent
Feeding:	☐ Independent	☐ Requires assistance	☐ Dependent

Mode of transfer:
☐ Independent
☐ 1-2 person assist
☐ Ceiling lift
☐ Slide board

Use of assistive devices:	
☐ Walker	☐ Wheelchair
☐ Cane	☐ Crutches
☐ Ceiling lift	
☐ Other:	

Spasticity assessment:

Presentation of spasticity (check all that apply):	☐ Upper limb (shoulder, elbow, wrist, or hand)	☐ L ☐ R ☐ Both		
	☐ Lower limb (shoulder, elbow, wrist, or hand)	☐ L ☐ R ☐ Both		
	☐ Other:			
Current adjunct therapies for spasticity (check all that apply):	☐ RMT	☐ Orthotics (braces), type:		☐ Baclofen
	☐ OT	☐ Cane	☐ Crutches	☐ Other:
	☐ PT	☐ Wheelchair	☐ Walker	
Previous Botulinum Toxin:	☐ No ☐ Yes, date of last injection:			
	Response to injections (detail):			
	Adverse reaction: ☐ No ☐ Yes, explain:			

Goal of therapy

Patient/staff goals (check all that apply):

☐ Decrease Pain	☐ Improve gait pattern
☐ Improve transfer	☐ Fall prevention
☐ Prevention of pressure sores	☐ Improve ROM
☐ Contracture management	☐ Improve dexterity/fine motor ROM
☐ Specific tasks:	

Other comments:

Referring physician name:

Referring physician signature:

Appended forms: ☐ Medical Report ☐ INR

**Incomplete forms will be delayed being seen.*