Clinical Care Pathway; ODFS

Patient Details Front Sheet

Name……. **DOB/ PID**…….	Address *(Attach label if available)*
Contact telephone numbers; Home…….. Work……. Mobile……..	Emergency contact details; Name……. Contact number……. Relationship to patient……

GP details — Referring doctor? Y N

Name; Practice address;

Telephone number;

Consultant details — Referring doctor? Y N

Name; Address;

Telephone number (if known);

Details of other professionals to be copied into correspondence

Current medication (give dose where known)

LEADING REHABILITATION
THROUGH TECHNOLOGY

Odstock Medical Limited

National Clinical FES Centre
Salisbury District Hospital
Salisbury
Wilitshire
SP2 8BJ
UK

Tel +44 (0) 1722 429065
Fax +44 (0) 1722 425263
enquiries@odstockmedical.com
www.odstockmedical.com

PATIENT CONTRACT

Date……

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 ……**

Clinician sign…… **Print……**

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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 purposes. ☐
6. I give my permission to use video recordings or photography for promotional purposes. ☐

Patient sign…… Print……Date……

Clinician sign……Print……Date……..

Copy this page when signed; 1 for patient, 1 to be kept with hospital notes

ODFS Care Pathway ; set up

Date

Patient name…….

DOB/ PID ……..

(Attach label if available)

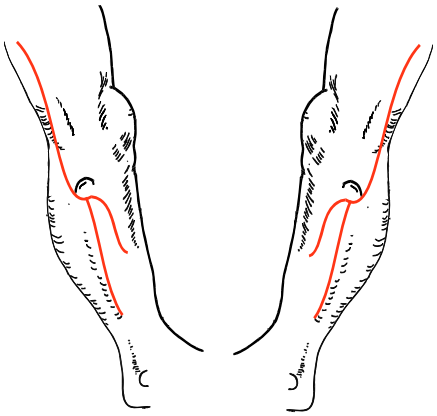
Clinician sign ……

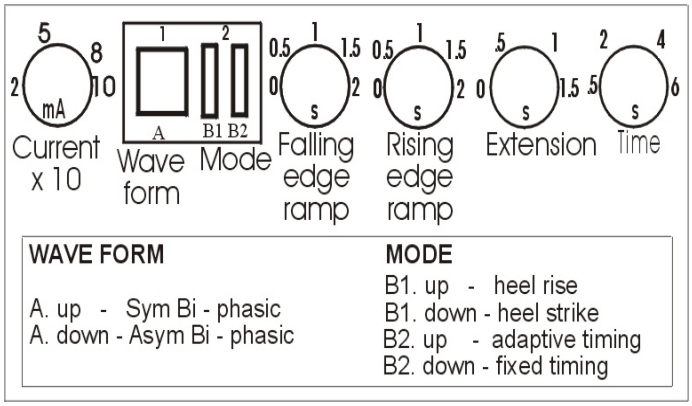
Print name……

Designation……..

	Treated side (circle) L R		Clinician Initial	Not required
1	Implied consent			
2.	Changes to patient details/ medication recorded on front sheet			
3	**Patient/ carer education**	**Details if necessary**	**Clinician Initial**	**Not required**
3a	Procedure for donning and doffing			
3b	Test procedure			
3c	Electrode positioning			
3d	Electrode care			
3e	Skin care			
3f	Footswitch positioning and insertion			
3g	Written / photographic instructions issued			
3h	Precautions given			
4a	**Skin checked on day 1**			
4b	**Skin checked on day 2**			
4c	**Skin irritation form completed**			
5	**Electrode positions found / recorded**			
6	**Stimulation parameters set / recorded**			
7	**Technical information recorded**			
8	**Consent forms completed**			
9	**Problem list, treatment plan and goal sheet completed**			
10.	**10 metre walks completed**			
11	**Patient Handling Profile completed**			
12	**Consumables issued**			
12a	Up to 3 packs of electrodes	Type:		
12b	Up to 2 footswitches	FSR position:		
12c	1 electrode lead	Length:		
12d	1 footswitch lead	Length:		
12e	Up to 2 insoles	Size:		

ODFS Care Pathway; set up	Date
Patient name……	Clinician sign……
DOB/PID……	Print name……
(Attach label if available)	Designation……





MICROSTIM DETAILS	Serial number:

10 metre walk	Walking aid;				RHR
	Time	HR	HR increase	Speed m/s	PCI
Walk 1 (no FES)					
Walk 2 (no FES)					
Walk 3 (with FES)					
Walk 4 (no FES)					
% Change with stimulation					
% Change since 1st assessment (NS)					

Additional Comments

ODSTOCK MEDICAL LTD
EQUIPMENT RECEIPT FORM

THIS TABLE DETAILS THE EQUIPMENT THAT YOU HAVE BEEN GIVEN:

Name……. DOB/ PID……. Date……..

Equipment Type	**ODFS Single Channel**	**O2CHS Two Channel**	**O4CHS Four Channel**	**MS2 Two Channel**	**[Other]***
Serial Number					
Instructions Supplied					
Signature of User					
Signature of Clinician					
Date Equipment Returned					
Name and Signature (received by):					

* Use this column for one off or custom made devices. They may not be CE marked but they will meet all Medical Device requirements.

Set-up; Problem list, treatment plan and goal sheet

Patient name……. DOB/PID…….. *(Attach label if available)*	Clinician sign……. Print…….. Date……

Date	Problem identified	Treatment plan	Clinician initial
	Unilateral foot drop	ODFS	
	Bilateral foot drop	02CHS	
	Increased calf tone limiting response to ODFS	MS2 V2	
		Other……	
	Reduced ROM limiting response to ODFS	MS2 V2	
		Other……	
	Lack of ankle stability on stance phase; uncontrolled by FES	ODFS + orthosis; type?.....	
	Hypersensitive to sensation of stimulation	MS2 V2	

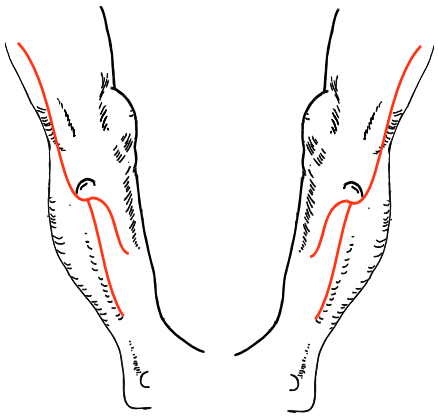
Date set	Patient-specific objectives (in 18 weeks)	Outcome measure (where appropriate)	Date achieved

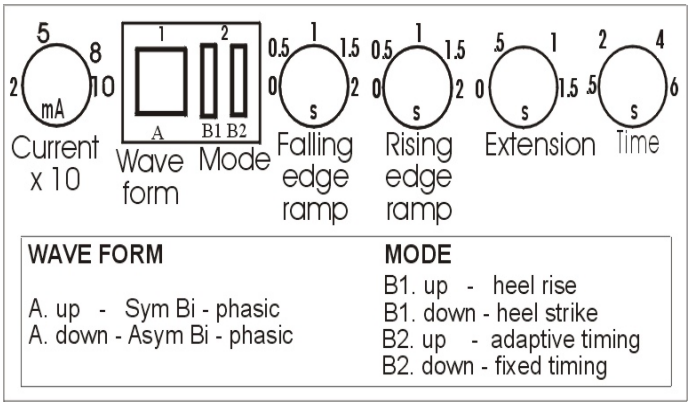
Date set	Objectives for long term use	Outcome measure (where appropriate)

ODFS Care Pathway ; review	Date
Patient name……. DOB…….. *(Attach label if available)*	Clinician sign …….. Print name…….. Designation……

	Treated side (circle) L R		**Clinician Initial**	**Not required**
1	Implied consent			
2.	Changes to patient details and medication recorded			
3	**Patient/carer education- ODFS**	**Details if necessary**	**Clinician Initial**	**Not required**
3a	Procedure for donning and doffing			
3b	Test procedure			
3c	Electrode positioning			
3d	Electrode care			
3e	Skin care			
3f	Fault finding			
3g	Written/photographic instructions issued			
4a	**Skin checked**			
4b	**Skin irritation form completed**			
5	**Stimulation parameters reviewed and recorded**			
6	**Technical information recorded**			
7	**Patient videoed**			
8	**Problem list, treatment plan and goal sheet reviewed**			
9	**10 metre walks completed**			
10	**Patient Handling Profile completed**			
11	**Consumables issued**			
11a.	Up to 3 packs of electrodes	Type:		
12b.	Up to 2 footswitches	FSR position:		
12c.	1 electrode lead	Length:		
12d.	1 footswitch lead	Length:		
12e.	Up to 2 insoles	Size:		

ODFS Care Pathway; review	Date
Patient name…… DOB…….. *(Attach label if available)*	Clinician sign …… Print name …….. Designation……..





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% Change with stimulation					
% Change since 1st assessment (NS)					

Additional Comments

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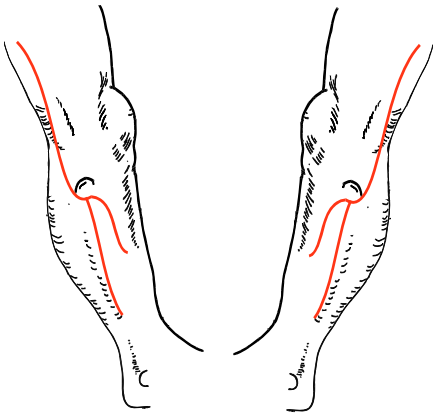
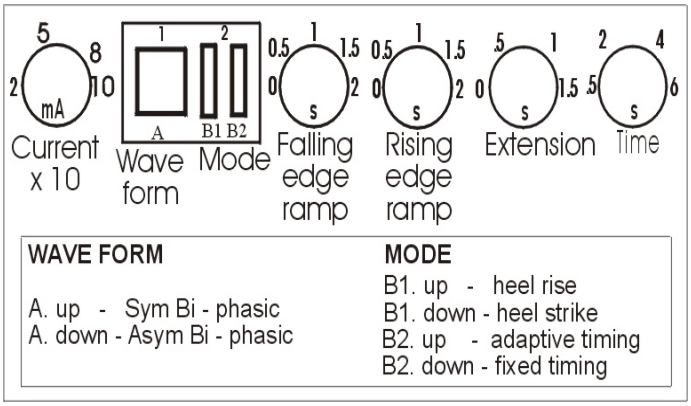
ODFS Care Pathway; review	Date
Patient name…… DOB…… *(Attach label if available)*	Clinician sign…… Print …… Designation……





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Additional Comments

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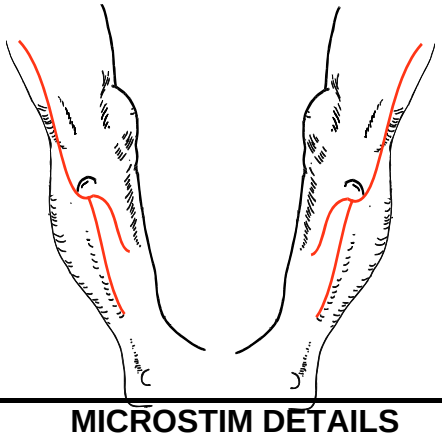

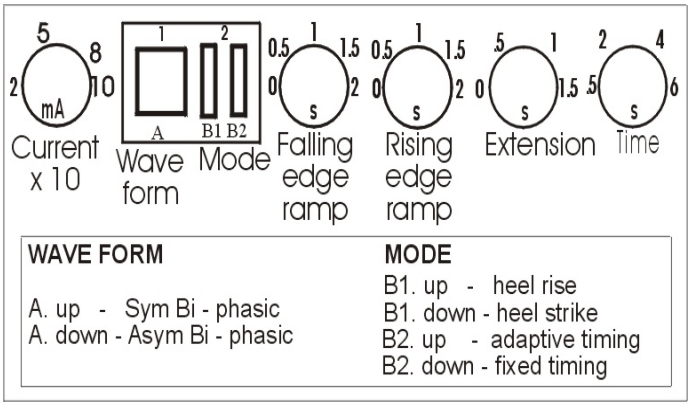

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Walk 3 (with FES)					
Walk 4 (no FES)					
% Change with stimulation					
% Change since 1st assessment (NS)					

Additional Comments

Patient Handling Profile

Patient details:

Name …… DOB …… PID ……

Handling Considerations

Height …….. Pain……..

Weight …….. Motor Deficit……

Eyesight..... Skin Integrity……

Hearing ..... Falls History …….

Mental Status/ Comprehension ……..

Transfer	Independent	Requires Assistance	Additional Aids
Sitting to standing	☐	Handling belt plus 1 person ☐ Handling belt plus 2 people ☐	
Bed/chair to chair	☐	Handling belt plus 1 person, step around ☐ Handling belt plus 2 people, step around ☐ Hoist ☐	
Walking	☐	Handling belt plus one person ☐ Handling belt plus 2 people ☐	

Date of assessment…….Name……Signature…….

Designation……..

Amendment/ Review date						

Signed..... Printed..... Designation..... Date.....

Patient Handling Profile

Date of amendment	Task amended	Reason for change	New recommendation	Name/ signature/ designation

Discharge summary ODFS & O2CHS

Name:_____ 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 were 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……..

(Attach label if available)

Clinician sign ……. Print……. Designation…….. Date……

Versions	Changes	Author and date
2	Care pathway – combination of previous forms and extra detail	C.Jolley 22/11/07
	Date for review	January 2008

For FES Research information:

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