Patient Qualification and Selection Checklist

Please complete a form for each patient selected to participate in the NeuroRehab Clinical Consult Program.

Date of Clinical Consult _____

PLEASE PRINT CLEARLY.

Name _____
Last *First* *MI* *Degree*

Complete the contact information below, only if it has changed.

Work Address _____
Street Address *City* *State* *ZIP*

Work Phone Number _____ E-mail Address _____

Please fill out the following information, and email the completed form to info@NeuroRehabResource.org; or fax to 973-758-0052.

Preceptor Name _____
Last *First* *MI* *Degree*

Patient Information _____ ❑ Male ❑ Female
Patient Number *Age*

Botulinum Neurotoxin Patient Exclusion Criteria

❑ Has a known hypersensitivity to any ingredient in the botulinum neurotoxin preparation
❑ Has been diagnosed with myasthenia gravis
❑ Has been diagnosed with Eaton-Lambert syndrome
❑ Has been diagnosed with amyotrophic lateral sclerosis
❑ Has uncontrolled systemic disease
❑ Has evidence of a fixed major contracture in the target limb
❑ Is pregnant, planning on getting pregnant in the next 4 months, or is nursing
❑ Is currently using aminoglycoside antibiotics

Are there other treatments for which the patient does not qualify? ❑ Yes ❑ No

If yes, what are the reasons? _____

_____

Baseline Assessment of Patient

Date of last examination _____

In your opinion, is the patient medically and neurologically stable? ❑ Yes ❑ No

Does the patient have any cognitive deficits? ❑ Yes ❑ No

If yes, please describe. _____

_____

List current symptoms experienced by patient. _____

_____

Diagnosis _____

_____

Patient Qualification and Selection Checklist

Cause(s) of spasticity *(Please check all that apply.)* Date of onset

- ❑ Stroke _____
- ❑ Traumatic brain injury _____
- ❑ Spinal cord lesion _____
- ❑ Multiple sclerosis _____
- ❑ Degenerative diseases *(Please specify.)* _____

_____

_____

❑ Other *(Please specify.)* _____

_____

What are the specific goals for the patient's treatment? _____

_____

Date spasticity was first diagnosed _____

What is the stage of spastic paresis?

- ❑ Acute
- ❑ Subacute
- ❑ Chronic

What is the level of impairment caused by spasticity? _____

_____

_____

How was the level of impairment evaluated? *(Please check all that apply.)*

- ❑ Ashworth Scale
- ❑ Modified Ashworth Scale
- ❑ Tardieu Scale
- ❑ Barthel Index
- ❑ Gait analysis
- ❑ Joint range of motion
- ❑ Global Disability Scale
- ❑ Other *(Please specify.)* _____

_____

Does the patient have any fixed contractures? ❑ Yes ❑ No

If yes, please specify joint location and method of determination. _____

_____

Does the patient have spasticity-related pain? ❑ Yes ❑ No

Rate the pain by location. _____

_____

If yes, please specify any pain medication currently being used. _____

_____

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What therapies are being used to treat the patient? *(Please check all that apply.)*

❑ **Physical therapy**

❑ **Occupational therapy**

Oral medications

Muscle relaxants

❑ Baclofen

❑ Dantrolene

❑ Cyclobenzaprine

❑ Other *(Please specify.)* _____

Anxiolytics

❑ Diazepam

❑ Clonazepam

❑ Other *(Please specify.)* _____

α2-adrenergic agonists

❑ Tizanidine

❑ Clonidine

❑ Other *(Please specify.)* _____

Anticonvulsants

❑ Phenytoin

❑ Carbamazepine

❑ Topiramate

❑ Gabapentin

❑ Ethosuximide

❑ Other *(Please specify.)* _____

Chemodenervation

❑ Phenol *(Please specify date, dose, and location of injections.)* _____

_____

❑ Alcohol *(Please specify date, dose, and location of injections.)* _____

_____

❑ Botulinum neurotoxin A *(Please specify date, dose, and location of injections.)* _____

_____

❑ Botulinum neurotoxin B *(Please specify date, dose, and location of injections.)* _____

_____

Surgery

❑ Intrathecal administration of baclofen (infusion pump)

❑ Surgical lengthenings, transfers, or releases of individual muscles

(Please specify.) _____

Has the patient experienced any adverse events from any of the above treatments? ❑ Yes ❑ No

If yes, please list treatment and specific adverse event(s). _____

_____

_____

What therapies have been used over the course of spasticity treatment, including possible combination therapies? _____

_____

_____

List reasons why you have changed the course of the spasticity treatment, if applicable. _____

_____

_____

Signature _____ **Date** _____