HANDWORKS REGISTRATION AND CONSENT

Welcome to our clinic and thank you for taking the time to complete the following paperwork (3 sheets) which will help us treat you safely and effectively.

Sheet 1: REGISTRATION and CLAIM DETAILS

NAME:	**Date of Birth:**	**Hospital No.:** (if known)
ADDRESS:	**Phone: Home:**	
	Phone: Work:	
EMAIL:	**Mob:** (text to remind service offered)	
GP:	**MEDICAL INSURER:**	
OCCUPATION:	**EMPLOYER:**	
REASON FOR ATTENDING HANDWORKS :		
WHO REFERRED YOU:		

If non ACC please move to next sheet

<u>**INJURY CASE MANAGEMENT**</u> **(ie ACC)**	**YES**	**NO**	**CLAIM NUMBERS**
Have you completed an **ACC45 claim form** for this injury? (sometimes Dr. completes on PC)			(top right ACC45)
Who did you **first see** with this injury? And /or **who completed the medical side of ACC45?**			
Have you received an **acceptance letter** from ACC?			(in acceptance letter)

Date of injury: (nb if older than 1year your claim may not be active/discuss with therapist.)	**Injury description:**		**Left**	**Right**
Have you had any **THERAPY for this injury?** **Y / N**	Where:	When	No of visits:	
Have you had any **SURGERY for this injury?** **Y / N**	Surgeon/Clinic	When .	ACC approved	

Did your injury **occur at work?** **Y / N**	Does your employer use **a separate Insurer for work injuries?**

Current work situation.(tick or circle)	Working full duties	Restricted duties	Off work (ACC)	Unemployed	Not working: ie student / parent / retired

Sheet 2: General Health, Consent and Outcome Measure
Please complete for Therapist to view before treatment

GENERAL HEALTH QUESTIONAIRE: Thank you for completing this information in order for us to treat you **safely.**	**Yes**	**No**	**Detail**
Are you being treated for any **medical condition** that may affect or be affected by our treatment of you? (eg, asthma, arthritis, angina, allergies, cancer, diabetes, infection, skin condition, other)			
Are you taking any significant or long term **medications**?			
Do you wear a **hearing aid** or have a **pacemaker**?			
If female; could you be **pregnant**?			
Do you have any **metal implants**?			
Have you had any **previous surgery** to this limb?			
Any **other health information** you feel we should know about?			

CLIENT CONSENT: **To be completed before start of treatment**

Please read carefully then sign and date. If you have any queries please ask staff member.

In accordance with the Privacy Act all information recorded on your records will be kept confidential.
Your records will only be accessed by the person providing your care and by those staff responsible for maintaining records.
You have the right of access to, and correction of, your personal information held by this practice.
No information will be given to a third party without your consent; however under ACC regulations you have already agreed to the collection and disclosure of information to ACC about your case, to the extent necessary to determine/assess entitlement for treatment.

- ***I hereby give consent to undertake treatment with Handworks; bearing in mind a full verbal explanation will be given at the time of treatment , affording me the right to decline all or part of the treatment offered to me at that time.***
  Under ACC regulations you also accept that you have to take personal responsibility for your rehabilitation and to actively participate in the treatment plan developed.
- ***I undertake to pay the costs of any treatment and /or materials where these are not covered by ACC or my employer***

  This includes retrospective fees, if any ACC or Insurance claim is declined once treatment has commenced.
  Any outstanding debts may be transferred to a third party: in the event of which you would be liable for the added recovery costs.
  All mailed accounts will incur an account fee.

NB. Non attendance / failure to advise 24 hours prior, will be charged at a rate currently posted in practice.

CLIENTS / CAREGIVER SIGNATURE:	**PRINTED NAME:**	**Date:**

PAIN AND FUNCTION OUTCOME MEASURE (please complete over page)

As Health providers we are interested in **evaluating** the **effectiveness of our treatment and your outcome.**
To do this we need **a measure of your pain and function** at the beginning of treatment, so we can compare during and at the end of treatment. Your completion of the questions overleaf will help us measure this.

Thank you

PTO….

Name: ______________________ Date: ______________ Score: __________

ACC No: ______________________________ Read code: ______________

PATIENT RATED WRIST/HAND EVALUATION

*The questions below will help us understand how much difficulty you have had with your wrist /hand in the past week. You will be describing your **average** wrist/hand symptoms **over the past week** on a scale of 0 – 10. Please provide an answer for **ALL** questions.*

- *If you did not perform an activity, please **ESTIMATE** the pain or difficulty you would expect.*
- *If you have **never** performed the activity, you may leave it blank.*

1. PAIN

Rate the average amount of pain in your wrist/ hand over the past week by circling the number that best describes your pain on a scale from 0-10.

- *A **zero** (0) means that you did not have any pain and*
- *A **ten** (10) means that the pain is the worst possible (i.e worst you have ever experienced or that you could not do the activity because of pain)*

If you are unable to use your hand because it is immobilised (ie POP) , or movement is prohibited (ie post op),score 10.

RATE YOUR PAIN:	**None**										**Worst**
At rest	0	1	2	3	4	5	6	7	8	9	10
When doing a task with a repeated wrist/hand movement	0	1	2	3	4	5	6	7	8	9	10
When lifting a heavy object	0	1	2	3	4	5	6	7	8	9	10
When it is at its worst	0	1	2	3	4	5	6	7	8	9	10

How often do you have pain?	0	1	2	3	4	5	6	7	8	9	10
	Never										**Always**

2. FUNCTION

A. SPECIFIC ACTIVITIES

*Rate the **amount of difficulty** you experienced performing each of the items listed below – over the past week, by circling the number that describes your difficulty on a scale of 0-10.*

- *A **zero** (0) means you did not experience any difficulty and*
- *A **ten** (10) means it was so difficult you were unable to do it at all.*

	No difficulty										**Unable**
Turn a door knob using my affected hand	0	1	2	3	4	5	6	7	8	9	10
Cut meat using a knife in my affected hand	0	1	2	3	4	5	6	7	8	9	10
Fasten buttons on my shirt	0	1	2	3	4	5	6	7	8	9	10
Use my affected hand to push up from a chair	0	1	2	3	4	5	6	7	8	9	10
Carry a 10lb (4kg) object in my affected hand	0	1	2	3	4	5	6	7	8	9	10
Use bathroom tissue with my affected hand	0	1	2	3	4	5	6	7	8	9	10

B. USUAL ACTIVITIES

*Rate the **amount of difficulty** you experienced performing you **usual** activities in each of the areas listed below, over the past week, by circling the number that best describes your difficulty on a scale of 0-10. By 'usual activities', we mean the activities you performed **before** you started having a problem with your wrist/hand.*

- *A **zero** (0) means that you did not experience any difficulty and*
- *A **ten** (10) means it was so difficult you were unable to do any of your usual activities.*

Personal care activities (dressing, washing)	0	1	2	3	4	5	6	7	8	9	10
Household work (cleaning, maintenance)	0	1	2	3	4	5	6	7	8	9	10
Work (your job or usual everyday work)	0	1	2	3	4	5	6	7	8	9	10
Recreational activities	0	1	2	3	4	5	6	7	8	9	10

Score = sum 5 pain items + (sum 10 function items) MacDermid & Tottenham (2004)