

I.M.P.R.E.S.S.
(Proximal Tibia)
Inclusion/Exclusion Criteria
To be completed by the PHYSICIAN

(For Internal Use Only)

Patient Study Number:	Completed By: _____ Clinic: _____
Visit Date (MM/DD/YY) □□ / □□ / □□	Visit Schedule (check appropriate box) <input checked="" type="checkbox"/> Pre-Op

EXCLUSION CRITERIA: *Must answer questions 1-16 “NO” for patient to qualify*

1.	Tibial shaft fracture not amenable to intramedullary nailing (i.e. fracture is less than 4 cm from joint surface)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2..	Fracture of the proximal tibia with intraarticular extension requiring open reduction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Known metabolic bone disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Separate displaced tibial tubercle fragment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Soft tissue injuries compromising treatment method with nail, plate, or both	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Fractures with vascular injury (Gustillo Type IIIC injury) requiring repair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Compartment syndrome of the leg diagnosed preoperatively	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Pathological fracture	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Retained hardware or existing deformity in the affected limb that would complicate IM nailing, plating, or both	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Symptomatic knee arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Surgical delay greater than 3 weeks for closed fractures or 24 hours for open fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Contralateral proximal tibia fractures (bilateral injury) or ipsilateral lower extremity injury that would compromise function of the knee	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Immunocompromised	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Unable to comply with postoperative rehabilitation protocols or instructions (i.e. head injured or mentally impaired)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Current or impending incarceration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16.	Unlikely to follow-up in surgeon’s estimation	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For any “YES” answers, please provide a brief description:

I.M.P.R.E.S.S.
(Proximal Tibia)
Inclusion/Exclusion Criteria
To be completed by the PHYSICIAN

(For Internal Use Only)

Patient Study Number:	Completed By: _____ Clinic: _____
Visit Date (MM/DD/YY) <input type="text"/> / <input type="text"/> / <input type="text"/>	Visit Schedule (<i>check appropriate box</i>) <input checked="" type="checkbox"/> Pre-Op

POST – SCREENING DATA CAPTURE

1. Does the patient qualify for the study?
 - Yes
 - No

2. If the patient qualified, was the patient randomized?
 - Yes
 - ➔ To Nail
 - ➔ To Plate
 - No, patient initially consented to randomization, but withdrew consent prior to randomization
 - No, patient did not sign the consent form

3. Why did the eligible patient choose NOT to participate in the study? (mark all that apply)
 - Not applicable
 - Not interested
 - Too much work
 - Other: _____