

I.M.P.R.E.S.S.

(Proximal Tibia)

Follow-up Clinical Assessment

To be completed by the PHYSICIAN

Patient Study Number	Completed By: _____
Clinic: _____	Visit Date (MM/DD/YY) ____ / ____ / ____
Visit Schedule (check appropriate box) <input type="checkbox"/> 2 mo <input type="checkbox"/> 3 mo <input type="checkbox"/> 6 mo <input type="checkbox"/> 12 mo <input type="checkbox"/> 24 mo	

Directions: Answer every question by filling in the correct circle or writing in the information. If you need to change an answer, completely erase or cross out the incorrect mark, initial, and fill in the correct information. **Mark only one answer for each question unless otherwise instructed. Shade circles like this: ●**

Please answer questions 01-03 at one follow-up only.

01. Date of definitive surgery (MM/DD/YY)

____ / ____ / ____

02. Date of definitive wound closure (MM/DD/YY)

____ / ____ / ____

03a. Type of definitive wound closure (Mark all that apply)

- ☐ Primary
☐ STSG
☐ Flap (Specify in 3b.)
☐ VAC assisted

b. If “Flap”, specify type

- ☐ Local muscle
☐ Fasciocutaneous
☐ Free

04. Was CPM used?

- ☐ Yes ☐ No

05. Surgical procedures performed since last follow-up

- ☐ Yes ☐ No (Skip to question 7)

06. If “Yes”, specify procedure and date performed

(Mark all that apply)

a. Procedure	b. Date (MM/DD/YY)
<input type="radio"/> Bone graft	____ / ____ / ____
<input type="radio"/> Dynamization	____ / ____ / ____
<input type="radio"/> Exchange nail	____ / ____ / ____
<input type="radio"/> Irrigation and debridement	____ / ____ / ____
<input type="radio"/> Remove painful implant - nail	____ / ____ / ____
<input type="radio"/> Remove painful implant – plate	____ / ____ / ____
<input type="radio"/> Remove painful implant – screws only	____ / ____ / ____
<input type="radio"/> Other (Specify below)	____ / ____ / ____

07. Complications since last follow-up

- ☐ Yes (Complete Adverse Event Form)
☐ No

Physical Exam

08a. Rotational alignment of affected extremity

- ☐ Normal (Skip to question 09)
☐ Internally rotated
☐ Externally rotated

b. If “Internally” or “Externally” rotated, specify degrees of rotation ____ °

09a. Leg length discrepancy

- ☐ None (Skip to question 10)
☐ Affected leg shorter than unaffected leg
☐ Affected leg longer than unaffected leg

b. If “Short” or “Long”, specify discrepancy

____ mm

For questions 10-13, fill in degree and either a positive (+) or negative (-) sign in the parenthesis.

10. Knee extension (0 = full extension, (+) = hyperextension)

- a. Active () ____ °
 b. Passive () ____ °

11. Knee flexion

- a. Active () ____ °
 b. Passive () ____ °

12. Ankle dorsiflexion (0 = neutral, (+) = dorsiflexion)

- a. Active () ____ °
 b. Passive () ____ °

13. Ankle plantarflexion

- a. Active () ____ °
 b. Passive () ____ °

14. Sensation at time of examination

Location	Normal	Diminished	Absent
a. Superficial peroneal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Deep peroneal nerve	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Posterior tibial nerve	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please continue on next page

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15. Manual muscle test (Using the guide below mark the one grade that best applies to the muscle in question)

Muscle Group	0	1	2	3	4	5
a. Quadriceps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Ankle dorsiflexors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Manual Muscle Test

Grade 5: Maximum resistance, full ROM

Grade 4: Strong to moderate resistance, full ROM

Grade 3: Full ROM against growth

Grade 2: Gravity eliminated, full or partial ROM

Grade 1: Gravity eliminated, muscles palpable

Grade 0: Gravity eliminated, no contraction

16. Returned to pre-injury weight bearing status

☐ Yes ☐ No

17. How much weight bearing has the patient been doing in the last 2 weeks?

- ☐ Weight bearing prevented due to other injuries
☐ None
☐ Toe touch
☐ Partial weight bearing
☐ Full weight bearing as tolerated

18a. Recommended weight bearing status (Current visit)

- ☐ Weight bearing prevented due to other injuries
☐ None
☐ Toe touch
☐ Partial weight bearing (Specify below)
☐ Full weight bearing as tolerated

b. If "Partial weight bearing", please specify

_____ lbs

19. Recommended ambulatory support (Current visit)

- ☐ Unable to ambulate ☐ One crutch
☐ Walker ☐ Cane
☐ Two crutches ☐ None

20. On a scale from 0 to 10, mark the patient's average level of pain at the fracture site/knee during weight bearing in the past week, with 0 being none and 10 being unbearable.

0 1 2 3 4 5 6 7 8 9 10

None | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | Unbearable

21. On a scale from 0 to 10, mark the patient's average level of pain during daily activities in the past week, with 0 being none and 10 being unbearable.

0 1 2 3 4 5 6 7 8 9 10

None | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | Unbearable

22. Frequency of pain medication use

- ☐ Never (Skip to question 24)
☐ Less than once a week
☐ Once a week
☐ Several times a week
☐ Daily
☐ Multiple times per day

23a. Type of pain medications used (Mark all that apply)

- ☐ Acetaminophen
☐ Narcotics
☐ NSAIDs
☐ Other (Specify): _____

24. Patient's Workers' Compensation status

- ☐ Currently seeking Workers' Compensation
☐ Workers' Compensation case settled
☐ Not planning on applying for Workers' Compensation

25. Patient's litigation status

- ☐ Currently involved in litigation
☐ Litigation settled
☐ Not planning on pursuing litigation

Radiographic Evaluation

26. Alignment on post-operative films

- a. _____° ☐ Varus or ☐ Valgus
 b. _____° ☐ Anterior angulation or ☐ Posterior angulation

27. Presence of callus

Location	None	Some	Bridging	Remodeled
a. Medial cortex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Lateral cortex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Anterior cortex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Posterior cortex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

28. Radiographically healed

- ☐ Yes ☐ No