Queensland Government Medical Aids Subsidy Scheme (MASS) Queensland Health

Queensland Artificial Limb Service
Clinical Prosthetic Clearance

(Affix identification label here if available)

URN:

Family name:

Given name(s):

Date of birth: Gender: ☐ M ☐ F ☐ I

Patient's Personal Details

1 Permanent Residential Address

Suburb	Postcode

2 Postal Address ☐ Same as residential address (for correspondence)

Suburb	Postcode

3 Contact information

Telephone
Mobile
Email

4 Eligibility Details

DVA Card Number

☐ N/A ☐ Gold ☐ White ☐ Orange

Medicare Card Number

☐ Green ☐ Yellow ☐ Blue

NDIS Participant Number
NDIS Plan Number

5 Residency Details

Country of Birth: ☐ Australia

☐ Other:

Date moved to Australia if other:

☐ Australian Citizen
☐ Permanent Resident Visa
☐ Protected Special Category Visa
☐ Other – Please provide details:

6 Is the patient seeking or is intending to seek compensation for their limb loss or prosthetic services e.g. Work Cover, NIISQ, Civil Claim, Public Liability?

☐ No ☐ Yes - Please provide details:

Patient's Amputation Details

7 Main Cause of Amputation

☐ Circulatory ☐ Congenital
☐ Complications of diabetes
☐ Infection ☐ Neoplastic
☐ Neurogenic ☐ Trauma
☐ Other - Please Specify

8 Amputation Details

Date of Amputation	Level of Amputation	Side of Amputation
		☐ Left / ☐ Right
		☐ Left / ☐ Right
		☐ Left / ☐ Right
		☐ Left / ☐ Right

9 If the client's amputation was caused by trauma or infection:

Date of accident or injury:

Place of accident or injury or cause of infection:
☐ Community ☐ Home
☐ Work Place ☐ Motor Vehicle
☐ Medical Negligence ☐ Other

Details:

10 Functional Rehabilitation Aims

☐ Transfers only OR
☐ Community and/or ☐ Home ambulation;
☐ with *or* ☐ without using other mobility aids;
☐ Other – please provide details:

Non-standard, occupational, recreational or sport specific components and/or prosthesis require evidence of clinical appropriateness and specific needs; evidence that the person has the functional capacity, physical attributes to participate, resilience and commitment to pursue the sport and training. Please provide details above and/or attach assessment to this clinical prosthetic clearance.

DO NOT WRITE IN THIS BINDING MARGIN

v.1.01 02/2020

SW395

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Patient's Clinical and Mobility Details

11 Mobility Assessment

Cardio-vascular fitness level: ☐ Low ☐ Medium ☐ High

Mobility Assessment Completed: ☐ No mobility assessments have been completed ☐ Yes – (please attach)

☐ Amputee mobility predictor assessment too (AMPAT) and/or ☐ another relevant standardised outcome

12 Co-Morbidities:

☐ Blindness or loss of sight in both eyes
☐ Blindness or loss of sight in one eye
☐ Cancer
☐ Cerebral Vascular Accident
☐ Charcot Joint
☐ Conditions and Diseases that affect motor skills:
  ☐ Amyotrophic Lateral Sclerosis (ALS)
  ☐ Arthritis
  ☐ Cerebral Palsy
  ☐ Essential Tremor (ET)
  ☐ Multiple Sclerosis (MS)
  ☐ Muscular Dystrophy (MD)
  ☐ Parkinson's Disease (PD)
  ☐ Spina Bifida
☐ Diabetes - ☐ Type 1 ☐ Type 2 ☐ Insulin Required
☐ Other:

☐ Eye Disease or Cataracts / Glaucoma
☐ Knee or hip transplants
☐ Knee or hip surgery
☐ Limb deformity on sound limb
☐ Mental Health (e.g. Depression, PTSD)
☐ Muscular and/or motor skill degeneration
☐ Neuropathy opposite upper/lower limb
☐ Obesity
☐ Organ Transplant (e.g. Kidney, Heart)
☐ Partial amputation on sound limb e.g. toes, digits
☐ Peripheral Vascular Disease
☐ Poor skin integrity on residual limb
☐ Renal Disease
☐ Spinal cord and/or back injuries
☐ Ulcers on residual and/or on sound limb

13 Height and Weight

Height cm Weight kg ☐ with *or* ☐ without a prosthesis

14 Prosthesis Details

Socket Type: ☐ Gel Liner used Time on interim program:

15 Prosthetic Suitability

Yes	No	
☐	☐	The patient has shown to have general muscle strength and endurance
☐	☐	**Interim Rehabilitation Program:** The patient has been assessed by the MDT as being suitable to start using an interim prosthesis or osseointegration light limb as part of their rehabilitation.
☐	☐	The patient's stump size and shape is in a stabilised condition
☐	☐	The patient is able to don on/off their prosthetic limb
☐	☐	The patient has shown they are able to balance while using prosthetic limb
☐	☐	The patient can safely mobilise on a prosthesis without the use of other aids
☐	☐	**Definitive:** The patient has been assessed by the MDT, has completed the interim rehabilitation program and has being suitable to use a definitive prosthesis or Osseointegrated limb.

Clinical Clearance Acknowledgement

MDT Member Signature	MDT Member Name	Date
Position	Hospital and Health Service (HHS)	Amputee Clinic

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