

Universal Data Collection

U.S. Department of Health
and Human Services

Public Health Service

Annual Visit



CDC ID

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GENERAL INFORMATION

Date of visit	Date form completed	Form completed by	Data entered by																								
<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td>Month</td><td>Day</td><td>Year</td></tr></table>							Month	Day	Year	Month	Day	Year	<table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td>Month</td><td>Day</td><td>Year</td></tr></table>							Month	Day	Year	Month	Day	Year	<input type="text"/>	<input type="text"/>
Month	Day	Year	Month	Day	Year																						
Month	Day	Year	Month	Day	Year																						
			CDC Use Only																								

DEMOGRAPHIC INFORMATION

1. Zipcode: <table border="1"><tr><td> </td><td> </td><td> </td></tr></table> (first 3 digits)				5. Employment status (check one): <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Not employed If not employed , check one of the following: <input type="checkbox"/> Child or student <input type="checkbox"/> Homemaker <input type="checkbox"/> Able, but not currently working <input type="checkbox"/> Permanently disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other _____	7. Health Insurance (check all that apply): <input type="checkbox"/> Straight commercial insurance <input type="checkbox"/> Commercial insurance HMO <input type="checkbox"/> Commercial insurance PPO <input type="checkbox"/> Straight Medicare <input type="checkbox"/> Medicare HMO <input type="checkbox"/> Straight Medicaid <input checked="" type="checkbox"/> Medicaid HMO <input type="checkbox"/> TRICARE <input type="checkbox"/> State high-risk insurance plan <input type="checkbox"/> Uninsured <input type="checkbox"/> Other _____	
2. Weight: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table> kg					6. HTC utilization (check one): <input type="checkbox"/> Frequent (visits HTC once per year) <input type="checkbox"/> Infrequent (visits HTC every 2-3 years) <input type="checkbox"/> Rare (visits HTC every 4 or more years) <input type="checkbox"/> First visit	8. Has the patient had an analysis of his or her genetic mutation since birth or the last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Height: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table> cm						
4. Education: Check the highest education level <u>completed</u> by patient <input type="checkbox"/> Pre-elementary <input type="checkbox"/> Primary / Secondary Enter grade 1-12 <table border="1"><tr><td> </td><td> </td></tr></table> <input type="checkbox"/> Technical school <input type="checkbox"/> College degree <input type="checkbox"/> Advanced degree <input type="checkbox"/> Other _____						
4a. Current student: <input type="checkbox"/> Yes <input type="checkbox"/> No						

TREATMENT INFORMATION

9. Treatment type (check one): <input type="checkbox"/> Episodic care <input type="checkbox"/> Immune tolerance <input type="checkbox"/> Prophylaxis If prophylaxis , <input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent	12. Bleeding episodes in the last 6 MONTHS (If none, enter zero): Based on infusion logs OR Estimated by patient recall Number of joint bleeds _____ OR _____ Number of muscle bleeds _____ OR _____ Number of other bleeds _____ OR _____	13. Intracranial hemorrhage (ICH) since last annual visit? <input type="checkbox"/> Yes <input type="checkbox"/> No 13a. If yes, date <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>Month</td><td>Day</td><td>Year</td><td>Month</td><td>Day</td><td>Year</td></tr></table> 13b. If yes, associated with <input type="checkbox"/> Trauma <input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Other _____							Month	Day	Year	Month	Day	Year
Month	Day	Year	Month	Day	Year									
10. Highest inhibitor titer since and including the last visit: (Bethesda units): <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table> <input type="checkbox"/> not done						14. Home infusion? <input type="checkbox"/> Yes <input type="checkbox"/> No 14a. If yes, infused by (check all that apply) <input type="checkbox"/> Patient <input type="checkbox"/> Family member <input type="checkbox"/> Medical care provider								
11. Immune tolerance therapy since the last annual visit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes , <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful														

ANNUAL VISIT FORM

FORM COMPLETION: Complete this form for all consenting, eligible patients attending the treatment center. If this is the first visit for which this form is being completed, substitute "during the previous 12 months" for the phrase "since the last annual visit."

Patient CDC ID: The unique 12-digit number generated for each patient by staff at the hemophilia treatment center (HTC) using the CDC ID computer program.

General Information: Enter the date of the visit and the date that this form was completed. Enter the initials of the person completing the form.

DEMOGRAPHIC INFORMATION

1. Zipcode of Residence: Enter the first three digits of the zipcode for the patient's residence (NOT for the HTC that the patient visits).

2. Weight & 3. Height: Enter the patient's weight in kilograms and height in centimeters without shoes and in light clothing; (2.2 lbs = 1 kg) (1 inch = 2.54cm). To convert pounds to kilograms divide by 2.2. To convert inches to centimeters multiply by 2.54.

4. Education: As of the date of the visit, check PRIMARY / SECONDARY and enter the highest completed grade level for grades 1-12 or check appropriate box for education beyond high school. Check PRE-ELEMENTARY if the participant has not begun elementary school or has not completed the first grade.

4a. Current Student: As of the date of the visit, check YES if the patient is a full-time or part-time student. Otherwise, check NO.

5. Employment status: As of the date of the visit, check the employment status of the patient. If EMPLOYED, check either FULL-TIME or PART-TIME. If NOT EMPLOYED, check the most appropriate reason for unemployment. In order to check PERMANENTLY DISABLED, the patient must have qualified for disability income and must not work at all. In order to check RETIRED, the patient must be of retirement age (usually >55 years) and not working at all.

6. HTC utilization: Use the history of patient visits to the HTC to determine whether the patient utilizes the HTC on a frequent, infrequent, or rare basis. Count only actual visits to the HTC, not phone contacts or written correspondence. Check FIRST VISIT if the current visit is the first visit to the HTC.

7. Health insurance: Check all sources of health insurance coverage for the patient. Please see *Data Forms Manual* for more detail about health insurance plans.

Commercial Insurance: Insurance provided through private or public companies and paid for either by employers or by individuals.

Medicare: Federal health insurance program available to persons who are either over 65 years old or disabled.

Medicaid (Medical Assistance, Title 19): State/federal health insurance program for certain needy and low income individuals.

TRICARE: Insurance offered by the federal government to persons who are in the military and their dependents.

State High Risk Insurance Plan: State-sponsored insurance plan for individuals who have difficulty purchasing insurance due to a pre-existing condition.

Uninsured: Persons without any health insurance coverage.

Other: Any other type of health insurance plan not listed above.

8. Has the patient had an analysis of his or her genetic mutation: Check YES, if the patient has undergone genetic testing to determine the specific genetic mutation responsible for his/her bleeding disorder. If they have not undergone testing or if it is unknown, check NO.

TREATMENT INFORMATION

9. Treatment type (check one): If the patient received treatment products only in response to bleeding complications since the last annual visit, check EPISODIC CARE. If the patient is currently undergoing immune tolerance therapy (either initial or maintenance), check IMMUNE TOLERANCE. If the patient received treatment products to prevent bleeding or to prevent rebleeding, check PROPHYLAXIS. If you check PROPHYLAXIS and the patient was recommended to receive treatment products on a regular schedule to prevent any and all bleeding and this therapy was expected to continue indefinitely, check CONTINUOUS. If you check PROPHYLAXIS and the patient received treatment products on a regular schedule for a period of at least 28 days on at least one occasion since the last annual visit and this therapy was not expected to continue for an indefinite period of time, check INTERMITTENT. You should not check prophylaxis if the patient received treatment products for less than a period of 28 days.

10. Highest inhibitor titer since and including the last visit: Enter the *highest* inhibitor titer measured at or since the last annual visit. Do not include values measured at the current annual visit. If less than 1, enter 0 (zero) in the box before the decimal point when entering the test result.

11. Immune tolerance therapy since the last annual visit: If the patient received immune tolerance therapy since the last annual visit, check YES. If yes, also check whether the therapy was SUCCESSFUL or UNSUCCESSFUL. Check SUCCESSFUL *only* if the patient can be effectively treated for a bleeding episode with a factor dosage appropriate to his/her hemophilia severity and its type; otherwise, check UNSUCCESSFUL. Check NO if the patient did not receive immune tolerance therapy since the last annual visit. Check UNKNOWN if it is not known whether or not the patient received immune tolerance therapy since the last annual visit.

12. Bleeding into a joint, muscle, or other area: Enter the number of times in the last 6 MONTHS that the patient has had a bleed into a joint, muscle, or other area. Use infusion logs provided by the patient, if available. Otherwise, estimate as best as possible, the number of bleeds based on interview with the patient. Include bleeds which occurred secondary to medical procedures. If patient experienced no bleeds at one or more of the sites, enter 0 (zero) for that/those site(s).

13. Intracranial hemorrhage: Check YES, if the patient has received a diagnosis of an intracranial hemorrhage (ICH) by a physician since the last annual visit.

13a. If yes, indicate the date of first diagnosis

13b. Check whether the bleed was associated with TRAUMA, THROMBOCYTOPENIA, or some OTHER complication.

14. Home infusion: Check YES, if the patient receives treatment products intravenously outside of the medical setting.

14a. If YES, check whether the product is infused by the patient, a family member, or a medical care provider. If the patient receives treatment products only in a medical setting (e.g., HTC, emergency room), check NO.

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TREATMENT PRODUCTS

15. Treatment product(s) used since the last annual visit: (check all that apply)

- NONE USED UNKNOWN

Factor VIII, vWF, or Non-plasma Products

Recombinant FVIII

- Advate
- Helixate FS
- Kogenate FS
- Recombinate
- ReFacto
- Other, specify _____

Monoclonal FVIII

- Hemofil M
- Monarc-M
- Monoclate P
- Other, specify _____

Human FVIII containing VWF

- Alphanate
- Humate P
- Koate DVI
- Other, specify _____

Porcine factor VIII

- Other, specify _____

Blood bank products

- Cryoprecipitate
- Fresh-frozen plasma
- Platelets
- Packed RBCs or whole blood

Non-plasma and topical products

- Intravenous desmopressin (DDAVP)
- Nasal desmopressin (Stimate)
- Amicar
- Fibrin glue
- Other, specify _____

Factor IX, PCC, and Other Factor Products

Recombinant FIX

- BeneFIX
- Other, specify _____

Human FIX

- AlphaNine S-D
- Mononine
- Other, specify _____

Prothrombin complex

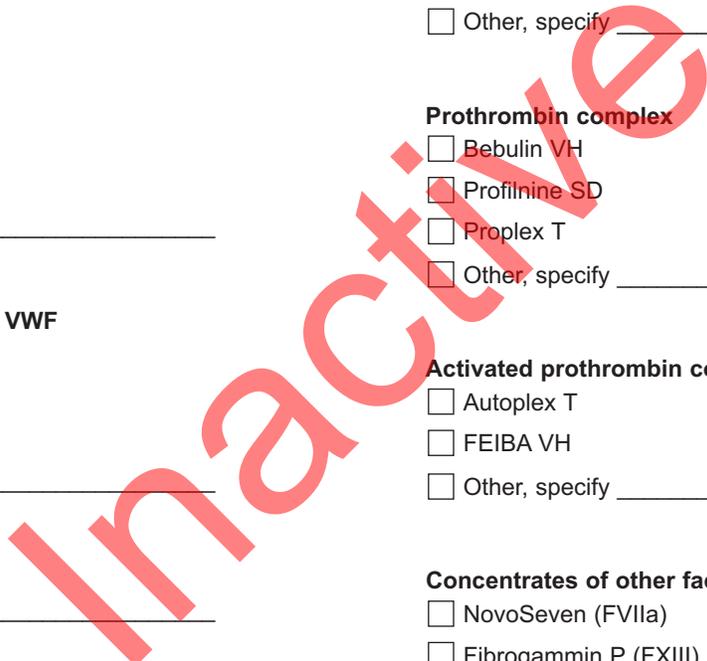
- Bebulin VH
- Profilnine SD
- Proplex T
- Other, specify _____

Activated prothrombin complex

- Autoplex T
- FEIBA VH
- Other, specify _____

Concentrates of other factors

- NovoSeven (FVIIa)
- Fibrogammin P (FXIII)
- Other, specify _____



ANNUAL VISIT FORM

15. Treatment product(s) used since the last annual visit: Check or enter all treatment products (including blood products, DDAVP, or Amicar) used by the patient since the last annual visit. Check NONE USED, if the patient did not use any treatment products since the last annual visit. Check UNKNOWN, if you do not know whether the patient used treatment products since the last annual visit or if you are unable to determine which products were used.

Inactive

INFECTIOUS DISEASE

16. Risk factors for liver disease:

16a. Past/present hepatitis infection

Positive HBsAg and/or anti-HBC and/or anti-HBS in absence of vaccination.

Yes No Unknown/untested

Positive anti-HCV and/or RIBA and/or PCR

Yes No Unknown/untested

16b. Other risk factors (check all that apply)

History of alcohol abuse

Other _____ None

17. Signs or symptoms of liver disease since the last annual visit:

(check all that apply)

Jaundice Ascites Varices

Other _____ None

18. Does the patient have chronically elevated ALT/AST levels?

Yes No Not measured

19. Has the patient had an elevated prothrombin time (PT) since the last annual visit?

Yes No Not measured

20. Has the patient received any therapy for chronic viral hepatitis?

Yes No

20a. If yes, agent used (see reverse for brands): Pegylated Interferon

Interferon Ribavirin Lamivudine Other _____

20b. If yes, sustained response? Yes No Unknown

20c. Hepatitis C genotype: 1a or 1b other than 1a or 1b Unknown

21. Has the patient used a CVAD since the last annual visit?

Yes No

21a. If yes, type of CVAD (check all that apply) Port Catheter PICC

21b. If yes, any infection in CVAD since last visit? Yes No

RISK REDUCTION

22. What is the HIV status of the patient?

Positive **if positive and age ≥ 16 , go to item 23.**

Negative **if negative, skip to item 29.**

Untested **if untested, skip to item 29.**

23. Does the patient have a regular partner?

Yes No

24. If yes, has this patient's regular partner ever been tested for HIV? Yes No Unknown

24a. If yes, was the result positive? Yes No Unknown

25. How many pregnancies in patient or among any sex partners impregnated by this patient since the last annual visit? _____

26. How often is a condom used when having sex?

Does not have sex (practices abstinence)

Never

Less than 50% of occasions

Usually (50–89% of occasions)

Nearly always (90–99% of occasions)

Always

27. How many sex partners of this patient were tested for HIV since the last annual visit? _____

28. How many sex partners of this patient have tested newly positive for HIV since the last annual visit? _____

JOINT DISEASE

29. How often since the last annual visit has the patient used a cane, crutches, or walker for ambulation or mobility?

Never Intermittently Always

30. How often since the last annual visit has the patient used a wheelchair for mobility?

Never Intermittently Always

31. How many days since the last annual visit has the patient missed work or school because of lower extremity joint problems?

_____ days not applicable

32. How many days since the last annual visit has the patient missed work or school because of upper extremity joint problems?

_____ days not applicable

33. Has the patient experienced a joint infection since the last annual visit?

Yes No

34. Check the statement which best describes the patient's current overall activity level:

Unrestricted school/work and recreational activities

Full school/work with limited recreational activity levels due to pain, loss of motion, weakness

Limited school/work and recreational activity levels due to pain, loss of motion, weakness

Limited school/work, recreational activity levels, and self-care activity levels due to pain, loss of motion, weakness

Requires assistance from another person for school/work/self-care, and unable to participate in recreation due to pain, loss of motion, weakness

ANNUAL VISIT FORM

INFECTIOUS DISEASE INFORMATION

16. Risk factors for liver disease:

- 16a.** Past or present infection with hepatitis B or C based on previous laboratory testing (not clinical signs or symptoms). Laboratory test results that indicate past or present infection with HBV include a positive HBsAg and/or anti-HBc, or anti-HBs in the absence of vaccination. Test results that indicate past or present infection with HCV include a positive anti-HCV and/or RIBA, and/or PCR for HCV RNA.
- 16b.** Check or enter any other risk factors for the development of liver disease such as a history of alcohol abuse, or other exposures. Check NONE, only if the patient has no known risk factors for liver disease.

17. Signs or symptoms of liver disease: Check or enter any signs or symptoms of liver disease experienced by the patient since the last annual visit. Check NONE, if no signs or symptoms were present.

18. Chronically elevated liver enzymes: Check YES if ALT levels measured in the past were at least 1.5 times the upper limit of normal on at least two occasions separated by at least one month **and** the most recent measurement was within one year of this visit. Do not include measurements made at the current annual visit.

19. Elevated PT: Check YES, if a measured prothrombin time (PT) was greater than 1.5 times the upper limit of normal at or any time since the last annual visit.

20. Any therapy for chronic viral hepatitis: Check YES, if the patient has received antiviral therapy for chronic viral hepatitis **ever in the past** if this is the first time the form is being completed or since the last annual visit if the form is being completed in subsequent years.

- 20a.** If Yes, check whether therapy included pegylated interferon (PEG-Intron, Pegasys), interferon (Intron A, Roferon A), ribavirin (Rebetrol, Copegus, Ribasphere), lamivudine (3TC, Epivir) and/or some other agent (please stipulate which other agent). Check all that apply.
- 20b.** If Yes, check whether or not treatment resulted in a sustained response. A SUSTAINED RESPONSE is defined as normalization of the ALT level for at least 6 months after the end of therapy **AND** either seroconversion from HBsAg positive to negative (if treated for chronic hepatitis B infection) or from HCV RNA positive to negative by PCR (if treated for chronic hepatitis C infection).
- 20c.** Please check the Hepatitis C genotype. Check unknown if the genotype is not known.

21. Use of Central Venous Access Devices (CVAD): Check YES, if the patient used any type of CVAD at any time since the last annual visit. Otherwise, check NO.

- 21a.** If yes, check all types of CVAD used since the last visit. PORT is an internal CVAD that is placed surgically under the skin of the chest or arm and is accessed using a needle. CATHETER can be either tunneled or non-tunneled, permanent or temporary and is inserted directly into a central vein such as the subclavian, jugular, or femoral (e.g., Hickman, Broviac). PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) is inserted into a peripheral vein in the upper arm or leg and threaded into a central vein such as the subclavian or jugular vein.
- 21b.** If yes, also check whether or not the patient was diagnosed with an CVAD associated infection by a physician since the last annual visit.

RISK REDUCTION INFORMATION

22. HIV status of the patient: Check POSITIVE, if the patient has ever tested HIV antibody positive. Check NEGATIVE if the patient has tested HIV antibody negative. Check UNTESTED, if the patient has not been tested for antibodies to HIV or if the results of testing are not known.

23. Regular partner: Ask the patient if there is a person whom he/she has dated, lived with, or been married to for at least three (3) months.

24. HIV testing of patient's regular partner: Complete this item only if the patient has a regular partner. Check YES, if the patient's regular partner has ever been tested for HIV. If not, check NO. If it is not known whether the regular partner has been tested, check UNKNOWN.

- 24a.** If the regular partner has been tested, check YES if the test result was positive; check NO if the test result was negative. If the test result is not known, check UNKNOWN.

25. Number of pregnancies in patient or among any sex partners impregnated by this patient since the last annual visit:

Enter the number of pregnancies occurring in this patient or in those sex partners impregnated by this patient since the last annual visit. If none are known, enter 0 (zero).

26. Condom use: Ask the patient how often a condom is used when having sex (includes anal, vaginal, or oral). Check the category that most accurately reflects condom use.

27. Number of patient's sex partners tested for HIV since the last annual visit: Enter the number of sex partners of this patient who are known to have had HIV testing since the last annual visit. If none are known or none have been tested, enter 0 (zero).

28. Number of patient's sex partners testing newly positive for HIV since the last annual visit: Enter the number of sex partners of this patient who are known to have had a positive test for HIV for the first time since the last annual visit. If none are known or none have been tested, enter 0 (zero).

JOINT DISEASE INFORMATION

29 & 30. Use of cane/crutches or walker and use of wheelchair or equivalent since the last annual visit: If the patient never used the above, check NEVER. If the patient used one or more of the above but only with an acute bleeding episode, check INTERMITTENTLY. If the patient used one or more of the above with usual ambulation since the last visit, check ALWAYS.

31 & 32. Work or school missed because of a lower or an upper extremity joint problem since last annual visit: Enter the number of days since the last annual visit that the patient reports missing work or school because of a complication (e.g., bleed, infection, arthritis, pain) in a lower (#31) or an upper (#32) extremity. If the patient does not attend work or school, check NOT APPLICABLE.

33. Joint infection since the last visit: Check YES, if the patient experienced a physician-diagnosed infection in a joint since the last annual visit; otherwise, check NO.

34. Overall activity level: Check the statement that BEST describes overall current activity level as impacted by joint disease according to the patient.

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35. Ranges of motion

Date ROM measurements performed

Month		Day		Year			

CODES*

Not measured	Orthopedic appliance	Invasive procedure
A = Acute bleed	D = Cast	H = Arthrodesis
B = Post-op restrictions	E = Splint	I = Joint replacement
C = Other medical reason	F = Orthosis	J = Arthroscopic synovectomy
	G = Brace	K = Open synovectomy
		L = Radioisotopic synovectomy
		M = Other invasive procedure

*See reverse for definitions

Record ROM Endpoint			Check	Circle all codes that apply from list above		
Left	Joint and Measuring Position	Right	Target joint	Not measured	Orthopedic Appliance	Invasive procedure
Hip			Hip	Hip		
<input type="checkbox"/>	Extension (sidelying)	<input type="checkbox"/>	L: <input type="checkbox"/>	L: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	L: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	L: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
<input type="checkbox"/>	Flexion (supine)	<input type="checkbox"/>	R: <input type="checkbox"/>	R: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	R: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	R: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
Knee			Knee	Knee		
<input type="checkbox"/>	Flexion (supine)	<input type="checkbox"/>	L: <input type="checkbox"/>	L: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	L: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	L: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
<input type="checkbox"/>	Extension (supine)	<input type="checkbox"/>	R: <input type="checkbox"/>	R: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	R: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	R: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
<input type="checkbox"/>	Hyperextension (supine)	<input type="checkbox"/>				
Shoulder			Shoulder	Shoulder		
<input type="checkbox"/>	Flexion (supine)	<input type="checkbox"/>	L: <input type="checkbox"/>	L: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	L: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	L: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
			R: <input type="checkbox"/>	R: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	R: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	R: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
Elbow			Elbow	Elbow		
<input type="checkbox"/>	Flexion (supine)	<input type="checkbox"/>	L: <input type="checkbox"/>	L: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	L: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	L: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
<input type="checkbox"/>	Extension (supine)	<input type="checkbox"/>	R: <input type="checkbox"/>	R: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	R: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	R: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
<input type="checkbox"/>	Hyperextension (supine)	<input type="checkbox"/>				
<input type="checkbox"/>	Pronation (sitting)	<input type="checkbox"/>				
<input type="checkbox"/>	Supination (sitting)	<input type="checkbox"/>				
Ankle			Ankle	Ankle		
<input type="checkbox"/>	Dorsiflexion (sitting)	<input type="checkbox"/>	L: <input type="checkbox"/>	L: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	L: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	L: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M
<input type="checkbox"/>	Plantarflexion (sitting)	<input type="checkbox"/>	R: <input type="checkbox"/>	R: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	R: <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G	R: <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J <input type="checkbox"/> K <input type="checkbox"/> L <input type="checkbox"/> M

Ranges of motion measured by (check one): Physical therapist Other

35. Ranges of Motion:

Date Measured - Enter the date on which the ROM measurements were performed.

ROM Endpoint - Measure the ROM to the nearest degree using the techniques described in the UDC Joint Range of Motion Reference Guide. All measurements should be obtained by passively moving each joint to its endpoint. Record the ROM measurement endpoint for each joint under the column labeled LEFT or RIGHT as appropriate. If there is hyperextension in a joint, record the number of degrees of hyperextension as a positive number and place a zero in the extension box. The hip and knee extensions, ankle and elbow measurements may be a negative number (see the *UDC Joint Range of Motion Reference Guide* pp. 4-5 for details). Be sure to include the minus sign for a negative number.

Target Joint - If the joint being measured is currently designated as a target joint (defined as recurrent bleeding into the joint on four (4) or more occasions in the past 6 months), check the box in the target joint column under the appropriate joint. L = left and R = right.

Not Measured - If the joint ROM cannot be measured during this visit, circle the letter code(s) for the reason(s) that the joint ROM could not be measured. The codes for *not measured* are:

- A = Acute Bleed (Bleed which occurs within 24 hours of the visit)
- B = Post-operative Restrictions (Movement restrictions due to a procedure or recent surgery)
- C = Other Medical Reason (Any other medical reason)

Orthopedic Appliance -

If the patient has been prescribed or has used an orthopedic appliance on the joint being measured since the last annual visit, circle the letter code in the orthopedic appliance column under the appropriate joint. L= Left and R= Right. If more than one appliance was used since the last visit, circle all that apply. The codes for *orthopedic appliance* are:

- D = Cast (a solid rigid dressing made of plaster or fiberglass that is molded to a body part)
- E = Splint (an appliance often made of moldable plastic used for temporary support of a joint)
- F = Orthosis (an appliance often made of durable plastic by an orthotist for long-term joint support)
- G = Brace (an appliance often made of fabric or neoprene, including ace wraps, used for joint support during a sporting or work activity)

Invasive Procedure - If the patient has undergone an invasive procedure in the joint being measured since the last annual visit, circle the letter code in the invasive procedure column under the appropriate joint. L= Left and R= Right. If more than one invasive procedure was performed since the last visit, circle all that apply. The codes for *invasive procedure* are:

- H = Arthrodesis (Artificial ankylosis, fixation, or fusion)
- I = Joint Replacement (Artificial joint insertion)
- J = Arthroscopic synovectomy (Removal of synovium by endoscope)
- K = Open synovectomy (Removal of synovium using a surgical procedure to open the joint)
- L = Radioisotopic synovectomy (Removal of synovium by injection of radioisotopes)
- M = Other Invasive Procedure (Any other invasive procedure)

Measurements Made By -

Indicate by checking the appropriate box whether the ROM measurements were made by a physical therapist or by some other health care professional (e.g., nurse, physician, etc.).