SCREENING FORM FOR PARTIAL-HAND PROSTHESES

Return via mail, fax, or email to orders@npdevices.com

clinician name	email	phone
clinic	city, state	zip code

patient name or identifier	patient date of birth
cause of parital-hand limb difference? ☐ trauma ☐ congenital ☐ vascular compromise ☐ other: _____	dominant hand ☐ right ☐ left ☐ ambidextrous screening which hand for device ☐ right ☐ left ☐ bilateral
medical condition of the hand is stable? ☐ yes ☐ no date of limb loss (m/d/yy) _____ date of final surgical procedure (m/d/yy) _____	has the patient tried other prosthetic intervention? ☐ yes ☐ no
patient is currently in hand therapy? ☐ yes ☐ no have all therapy goals been acheived? ☐ yes ☐ no	are you seeking a referral to a certified prosthetist? ☐ yes ☐ no

is the patient experiencing any of the following?

☐ volume fluctuation ☐ limited range of motion ☐ sensation loss or hypersensitivity ☐ weakness
☐ chronic edema ☐ joint contracture ☐ skin concerns (scar, grafting, fragile) ☐ other: _____

PHOTOS - REQUIRED PHOTOS MUST INCLUDE BOTH HANDS

VIDEOS - take video of the patient's hand demonstrating full *flexion* and *extension* range of motion from a sagittal and palmar view

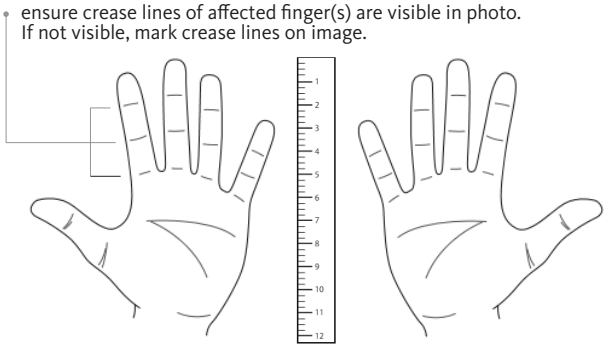

PHOTO A - fingers exended, palmar view

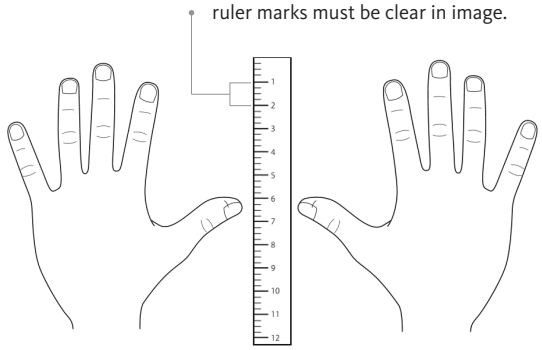

PHOTO B - fingers exended, dorsal view

PATIENT GOALS - Please list the top 5 goals the device(s) may assist your patient in achieving:

☐ ADLs (self care, dressing, buttons, hygiene, etc.)
☐ food preparation
☐ driving
☐ household maintenance
☐ childcare: _____
☐ animal care: _____
☐ other: _____
☐ occupation/employment: _____
☐ tool use (impact, vibratory, and/or bilateral required)
☐ weightlifting/other exercise: _____
☐ typing
☐ musical instrument: _____
☐ hobbies: _____

NAKED PROSTHETICS
For more information: (888) 977-6693 | (360) 915-9724 | fax (360) 918-8619 info@npdevices.com or visit npdevices.com
310 Adams St. NE Olympia, WA 98501