How to complete the proforma

Patients who are found to have shoulder pain are managed according to the ICP and all information relating to their shoulder pain is documented on a proforma: ***The Northwick Park Hemiplegic Shoulder Pain Protocol***.

The proforma should be placed in the patient's multi-disciplinary notes. Sections are shown below and on following pages, along with guidelines as to who should complete each part and when. Sheets are placed in the proforma for progress notes if needed.

Northwick Park Hemiplegic Shoulder Pain Protocol

Hemiplegic Shoulder Pain Protocol

Name: …….. Admission date:…./…./…..

Day 1 – Within 24 hours

Doctor's Assessment: Completing Doctor: …….. Date ……..

Tick if done

☐ **HSP Assessment Form (Preliminary Assessment Page 1)**

☐ **Ability to Complete Questionnaire** ☐ **Independent** ☐ **Able with help** ☐**Unable**

☐ **Shoulder Pain Questionnaire** *Administer with same type of help as AbilityQ*

Variance (reasons) i.e. if not done, say why and when

Initial Management:

Severity of shoulder pain ☐ **None** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Type of shoulder syndrome: ☐ **Hypotonic (Flaccid)** ☐ **Hypertonic (Spastic)**

Initial Analgesia: Current medication for HSP:……

Simple analgesia p.r.n:……

Other modalities: Heat / ice/……..

Other comments:

Liaison: Nurse:……Physio…….. O/T……

Investigations:

Tick if done		**Abnormal results:**	
☐ **Full Blood Count**	**Normal:** Yes / No		
☐ **U+E, LFTs**	**Normal:** Yes / No		
☐ **Erect AP shoulder x-ray** (if able to sit unsupported)			
Measurement of subluxation on x-ray		**Normal**	**Affected**
Vertical distance:	Inferior Acromial point – mid Humeral head:	…..mm	…..mm
Horizontal distance:	Mid-Glenoid – mid Humeral head:	…..mm	…..mm

1

There are several reasons for using this method of documention.

- It allows us to describe the nature and timing of management for shoulder pain in a systematic way.
- By keeping a record of situations where recommended intervention does not suit individual patients, we can achieve a better understanding of what works and what does not.
- We can use these records to audit the quality of our care against the standards we have set for best practice.

It is essential that all staff:

Document their assessments, their decisions about management and the interventions they use on the proforma.

Date and sign each entry.

Variance from the protocol:

It is especially important to record variance from the protocol in the spaces provided.

If equipment is not available, action is not carried out at the recommended time, or if the suggested intervention is not suitable for a particular patient, please make a note of this in the variance or comments sections.

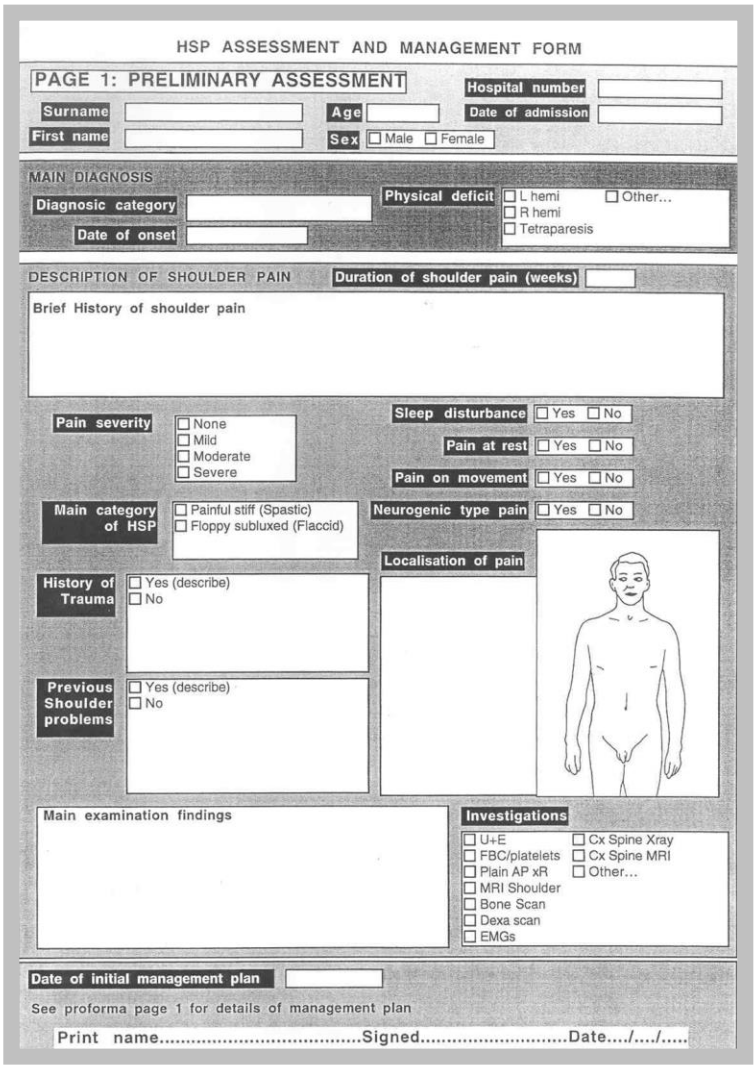
HSP Assessment and Management Form
Page 1: Preliminary Assessment

Within 24 hours of admission, a 'screening' assessment should be carried out by the admitting doctor. This aims to identify patients with a shoulder pain problem and to determine appropriate initial management.

Guidelines for medical aspects of assessment and management are detailed on pages 27-31 (pink sheets).

It is the doctor's responsibility to:

- Examine the patient to determine the presence and characteristics of shoulder pain.
- Record a brief pain history.
- Determine the patient's overall physical presentation.
- Evaluate the duration, site, severity and frequency of shoulder pain.


HSP ASSESSMENT AND MANAGEMENT FORM

PAGE 1: PRELIMINARY ASSESSMENT

Hospital number

Surname | Age | Date of admission

First name | Sex ☐ Male ☐ Female

MAIN DIAGNOSIS

Diagnosic category | Physical deficit ☐ L hemi ☐ R hemi ☐ Tetraparesis ☐ Other...

Date of onset

DESCRIPTION OF SHOULDER PAIN | Duration of shoulder pain (weeks)

Brief History of shoulder pain

Pain severity ☐ None ☐ Mild ☐ Moderate ☐ Severe

Sleep disturbance ☐ Yes ☐ No

Pain at rest ☐ Yes ☐ No

Pain on movement ☐ Yes ☐ No

Main category of HSP ☐ Painful stiff (Spastic) ☐ Floppy subluxed (Flaccid)

Neurogenic type pain ☐ Yes ☐ No

Localisation of pain

History of Trauma ☐ Yes (describe) ☐ No

Previous Shoulder problems ☐ Yes (describe) ☐ No

Main examination findings

Investigations ☐ U+E ☐ FBC/platelets ☐ Plain AP xR ☐ MRI Shoulder ☐ Bone Scan ☐ Dexa scan ☐ EMGs ☐ Cx Spine Xray ☐ Cx Spine MRI ☐ Other...

Date of initial management plan

See proforma page 1 for details of management plan

Print name.....Signed.....Date..../..../.....

- Arrange further investigations as necessary.
- Summarise findings on the ***HSP Assessment and Management Form – Page 1: Preliminary Assessment***
- Present the screening questionnaire (AbilityQ) and shoulder questionnaire (ShoulderQ) as appropriate, (see pages 8-11 for further details).
- Prescribe appropriate initial analgesia
- Liaise with nursing staff about the need to initiate the appropriate handling protocol.
- Liaise with therapy staff about the need to determine immediate positioning and support needs.
- Record these actions on page 1 of the proforma and note any reasons for variance from the protocol.

Ability to Complete a Questionnaire (AbilityQ)

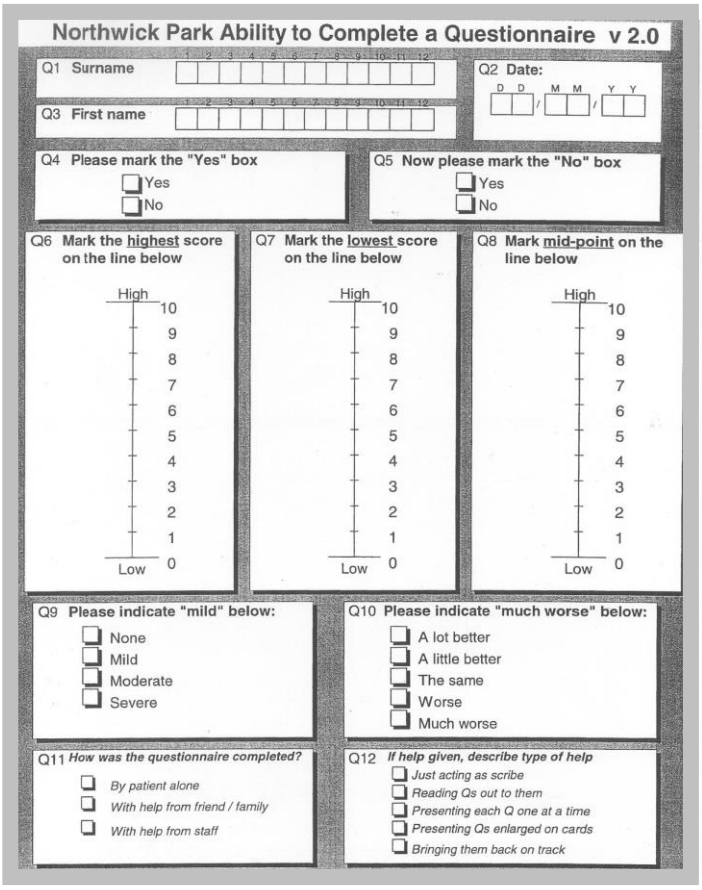
This is a screening tool which assesses the technical ability to answer questions in verbal or numbered VAS format and identifies the level of assistance needed for completion.

If patients find it hard to read, or if they are confused by the seven questions being on one sheet, each question can be presented in large print on separate cards.

Its purpose is to determine whether patients have the potential to self-report on their pain using the Northwick Park Shoulder Pain Questionnaire and if they have, to assist in interpreting their responses.

It is the doctor's responsibility to:

Present the AbilityQ to patients on the ICP within 7 working days of commencement.



Procedure for administration:

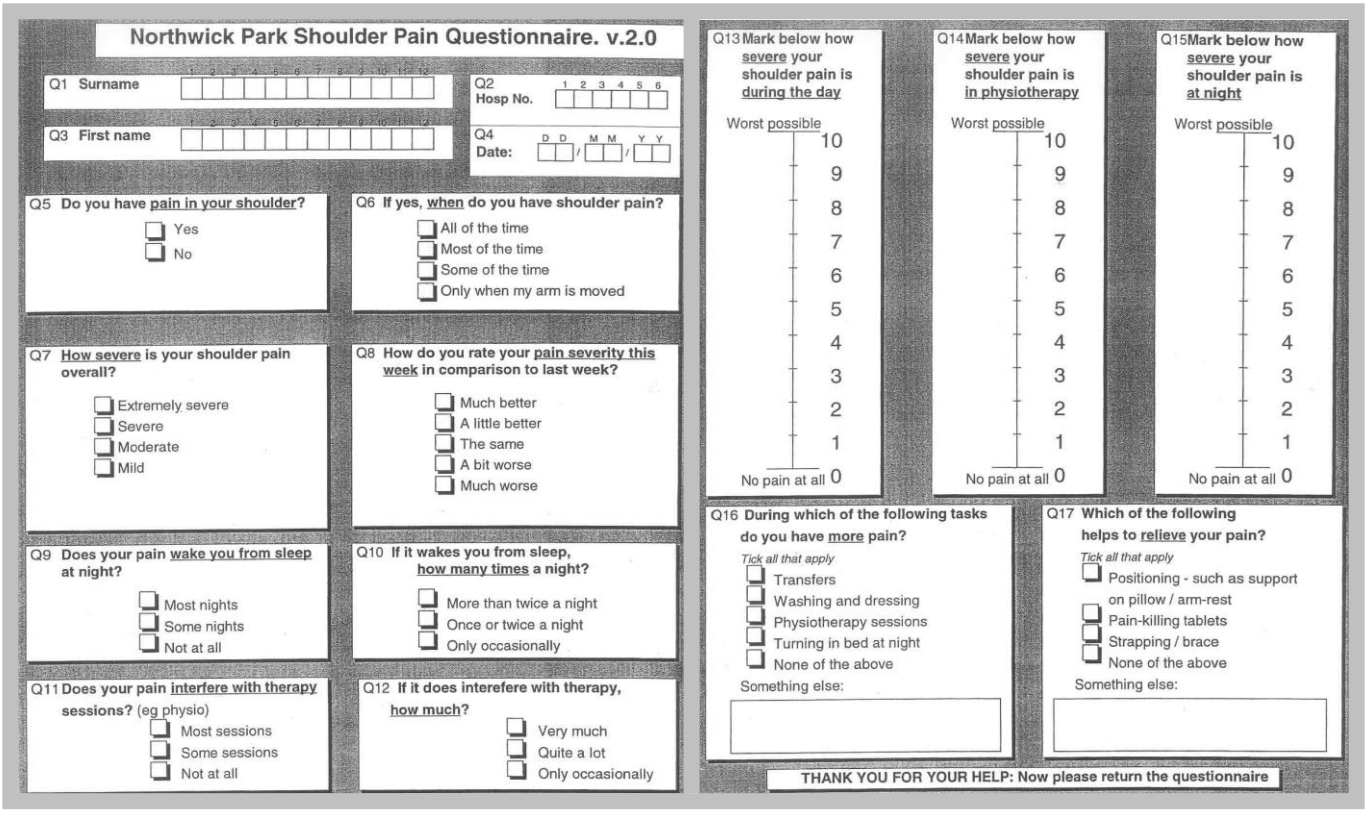
- Print the patient's name and the date that the questionnaire is presented in the boxes provided.
- Make sure the patient is positioned so that he/she can see all the questions clearly.
- If they have difficulty working out how to answer the questions, they may need help. For example, reading the questions aloud, writing their responses or keeping them 'on track'.
- Individual questions are available in large print if needed for patients with poor eyesight.
- Indicate how the questionnaire was completed in the boxes provided (Q11 and Q12).

Patients who successfully complete the AbilityQ should complete the ShoulderQ (see page 10) every two weeks while they are on the ICP.

The Northwick Park Shoulder Pain Questionnaire (ShoulderQ)

The ShoulderQ also contains questions in verbal and numbered VAS format.

- It is administered using the same level of assistance as deemed necessary from the AbilityQ
- It can also be presented in large print on separate cards.



Answers indicate the circumstances, timing and severity of pain. This provides a running record of how shoulder pain changes over time and informs any changes in intervention.

The ShoulderQ should be completed by patients each fortnight while they are on the ICP. When this has been done, check that the name and date are correctly entered on the top of the form and file it in the ICP section of the notes.

This action should be recorded in the multi-disciplinary review sections of the ICP proforma

The Pictorial Scale of Pain Intensity (SPIN)

The SPIN is a 6-point ordinal scale, coloured red for visual impact, with optional pictures (see below) conveying pain in different circumstances.

This system has been developed for patients who fail the AbilityQ screen; that is those with aphasia/cognitive impairment who are unable to use either verbal or numbered VAS scales. This group are unlikely to be able to complete a pain questionnaire in standard format.

A booklet has been designed to assist clinicians to evaluate the patient's ability to understand and respond to this way of self-reporting on pain. It acts as both a teaching and an assessment tool. Help from a speech and language therapist may be needed at the outset.

The booklet intersperses explanation with a series of questions which determine the ability to:

- Indicate Yes/No
- Distinguish between two pictures showing 'shoulder pain' and 'no pain'
- Point to each point on the SPIN (to make sure patients can see the whole scale)
- Indicate the site of shoulder pain on their own body
- Answer Yes/No to the question: *'Do you have pain in your shoulder at rest'?*
- Use SPIN to indicate answer to the question: *'How bad is the pain in your shoulder at rest'?*
- Repeat these two steps for: *'Pain on movement'* and *'Pain at night'*

A score sheet is used to record the patient's responses.

If these responses are correct and pain intensity ratings reflect the clinical impression, then we judge it reasonable to accept the patient's self-report as indicating their pain intensity. Additional support for this judgement could be acquired by test-retest.

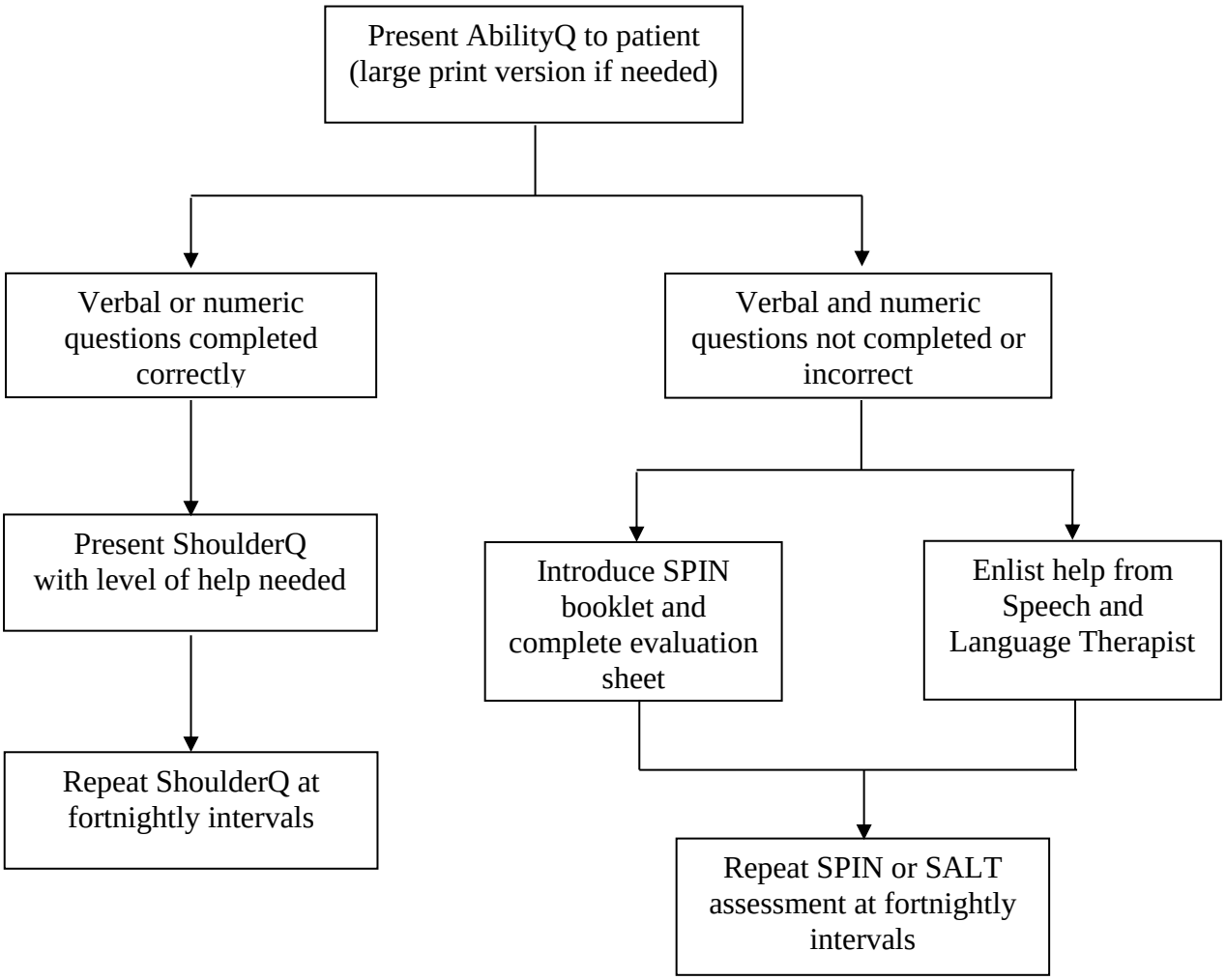
Once the patient can understand the scale, subsequent ratings can be made using laminated copies of the SPIN and pictures.

Flowchart to guide choice of pain assessment tools

The flowchart below should be used to guide pain assessment by self-report from the patient.

If they have communication and/or cognitive impairments of such severity that they are unable to self-report, a judgement will be made by the rehabilitation team as to whether pain appears to be better, the same, worse or resolved.

Whichever method is used to evaluate pain, a fortnightly record of pain status should be made on the multi-disciplinary review sheets in the proforma.



Positioning and handling

Based on an evaluation of the patient's physical presentation, an immediate positioning and handling regime will be recommended.

The following procedures should be implemented within 48 hours of ICP commencement. All actions should be recorded on the proforma, signed and dated.

Northwick Park Hemiplegic Shoulder Pain Protocol

Day 2: Within 48 hours

Nurse's Protocol: Completing Nurse: ……. Date ……..

Tick if done
☐ **Positioning chart above bed**

HSP protocol ☐ **Hypotonic (flaccid) shoulder (A)** ☐ **Hypertonic (spastic) shoulder (B)**

Other comments:

If protocol not initiated, give reason:

Support system: Completing O/T: ……. Date ……..

Recommended support system: (☐ None needed)

☐ **Arm-support on wheelchair:** ☐ Bexhill ☐ Ottobock ☐ Other……

☐ **Cushion in chair/wheelchair** ☐ Beanbag ☐ Pillow ☐ Other……

☐ **Personal** ☐ Strapping ☐ Sling Type:……..

Was recommended system provided? ☐ **No** ☐ **Yes**

(If not, given details in variance box below)

Other comments:

If not, reason for variance (eg recommended system not available, say what was done instead)

Documentation: Completing O/T / P/T: ……. Date ……..

Goal for management of HSP to be documented in notes

Tick if done
☐ **Goal:**

If not, reason for variance

2

It is the nurse's responsibility to:

Place an appropriate positioning chart above the patient's bed.

Please familiarise yourself with positions on pages 19-24 and nursing guidelines on pages 25-26 (yellow sheets).

There are two alternative positioning protocols for patients with uncomplicated needs:

A: Hypotonic (flaccid) shoulder

Chart A shows positioning in bed and in a chair for these patients.

B: Hypertonic (spastic) shoulder

Chart B shows positioning in bed and in a chair for these patients.

Complex positioning needs

If a patient has complex positioning needs, their physiotherapist and occupational therapist should prepare individualised positioning instructions to go above their bed.

It is accepted that this may take longer than 48 hours. If so, please make a note to this effect on the proforma.

It is the occupational therapist's responsibility to:

Select and supply an appropriate arm support system. Pages 32-34 (green sheets) detail the various options and the flowchart on pages 35-36 (green sheets) guides the choice of support.

It is the occupational therapist's and/or the physiotherapist's responsibility to:

Set one or more goals, specific to the management/reduction of the individual's shoulder pain.

These should be: **S**pecific **M**easurable **A**chievable **R**elevant **T**imely

Medication management and review

It is the doctor's responsibility to:

Determine an appropriate analgesia regimen in relation to timing and severity of shoulder pain.

This should be introduced, documented and dated on the proforma within 10 working days of commencement of the ICP.

Northwick Park Hemiplegic Shoulder Pain Protocol

Medication review: Completing Doctor: …… Date ……..

Pain severity at rest	☐ **None**	☐ **Mild**	☐ **Moderate**	☐**Severe**
Pain severity on movement	☐ **None**	☐ **Mild**	☐ **Moderate**	☐**Severe**
Interference with daily function	☐ **None**	☐ **Nursing tasks**	☐ **Therapy sessions**	
Night-time disturbance by pain	☐ **Yes**	☐ **No**		
Requests for prn analgesia/24 hrs	☐ **0**	☐**1-2**	☐**3-4**	☐**>4**
Pain Control	☐ **Satisfactory**	☐ **Not satisfactory**		
Contra-indications to NSAIDs	☐Gastric history	☐Anticoagulation	☐ Renal impairment	
NSAID use permissible	☐ Yes	☐With care	☐ **NO** – absolute contra-indication	

Suggested analgesic regimens (for information only)

Agent	**Persistent daytime pain**	**If Pain disturbs sleep Add:**	**If Pain interferes with therapy: Give 1 hour before**
NSAIDs (1st choice unless contra-indicated) *Precautions: Consider* ***Misoprostol protection***	Voltarol Retard 75mg morning **Alternatives** Naprosyn 250 mg tds Ibuprofen Retard 800mg od	Voltarol Retard 75mg evening Naprosyn 250mg nocte Ibuprofen Retard 800mg	Voltarol (normal) 25-50 mg ***NB Total daily dose must not exceed 150mg*** Naprosyn 250mg Ibuprofen 400mg
Regular simple analgesics	Paracetamol 1g tds	Paracetamol 1g nocte ± Temazepam 10mg	Co-proxamol ii 1hr before ***NB: Total dose of paracetamol not to exceed 4g per day***
Stronger analgesics *Precautions: consider* ***Lactulose / Senna***	Co-proxamol ii tds **Alternatives** Co-dydramol ii tds	Co-proxamol ii nocte ± Temazepam 10 mg Co-dydramol ii nocte	Ditto

Chosen medication regimen

Regular medication: ……

P.r.n medication: ……

Monitoring required: **Yes** ☐ **No** ☐ *(on NSAIDs: recommend monthly FBC / Biochem)*

Details:…….

Other: eg Nerve Block /Botulinum Toxin

Details:

3

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y

proforma.

They suggest management in cases where there may be:

- Soft tissue damage
- Osteopenia/occult fracture
- Reflex sympathetic dystrophy
- Neurogenic pain
- Cervical spondylosis

Further details of the medical management for these conditions can be found on pages 27-30 (pink sheets).

Two weekly medication reviews

Medication should be reviewed every 2 weeks while the patient is on the ICP.

Review should occur in the light of the patient's self-reported pain status either from the ShoulderQ, the SPIN or from team consensus where the patient is unable to self-report.

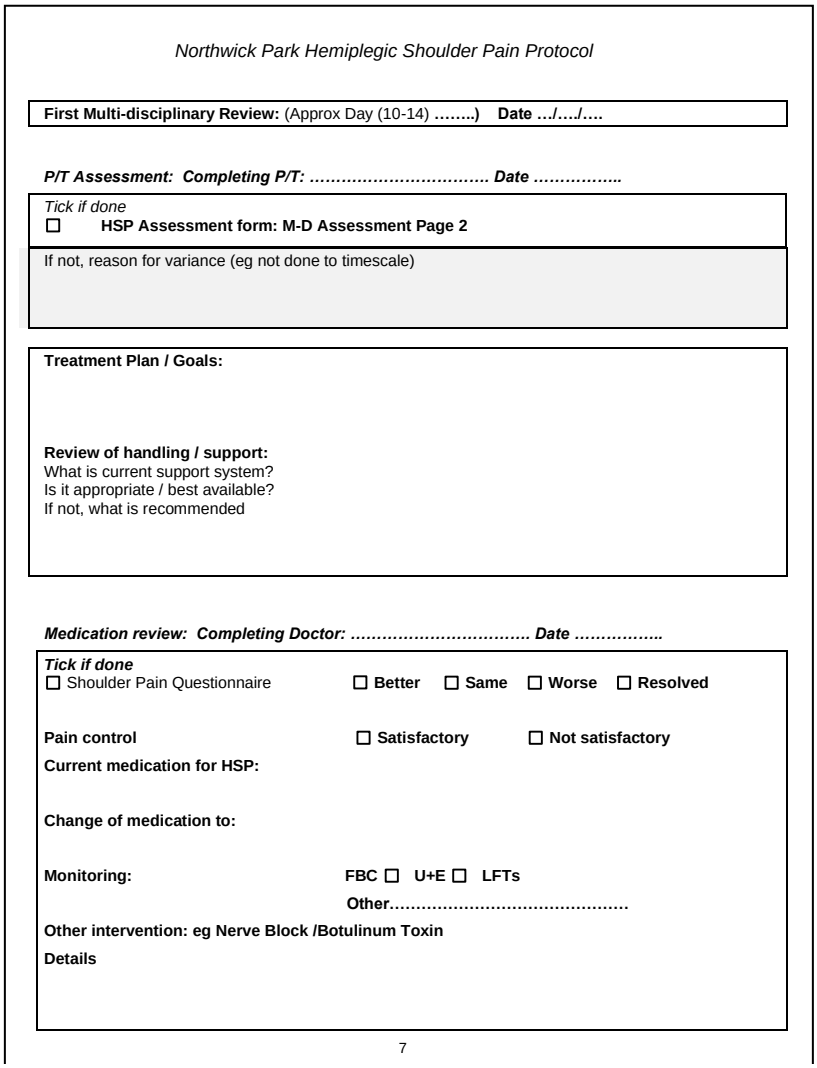
Responses should be summarised on the proforma.

This should be documented, signed and dated on the ***First Multi-disciplinary Review*** (page 14) and thereafter on the ***Subsequent Multi-disciplinary Review*** (page 16).

Multi-disciplinary management and review

*The **HSP Assessment and Management Form - Page 2: M-D Assessment** (see facing page) should be filled in jointly by **medical** and **physiotherapy** staff with input from **occupational therapy** staff as required to ensure that all parts of the form are completed.*

This should be done and documented, signed and dated on the proforma within ten working days of commencement on the ICP, otherwise variance should be recorded.



Northwick Park Hemiplegic Shoulder Pain Protocol

First Multi-disciplinary Review: (Approx Day (10-14) **……..)** **Date …/…./….**

P/T Assessment: Completing P/T: …… Date ……..

Tick if done
☐ **HSP Assessment form: M-D Assessment Page 2**

If not, reason for variance (eg not done to timescale)

Treatment Plan / Goals:

Review of handling / support:
What is current support system?
Is it appropriate / best available?
If not, what is recommended

Medication review: Completing Doctor: …… Date ……..

Tick if done
☐ Shoulder Pain Questionnaire ☐ **Better** ☐ **Same** ☐ **Worse** ☐ **Resolved**

Pain control ☐ **Satisfactory** ☐ **Not satisfactory**

Current medication for HSP:

Change of medication to:

Monitoring: **FBC** ☐ **U+E** ☐ **LFTs**
Other……

Other intervention: eg Nerve Block /Botulinum Toxin

Details

7

It is the physiotherapist's responsibility to:

Review the initial treatment plan and goals and adjust these if necessary in the light of the detailed assessment. See pages 37-39 (blue sheets).

It is the occupational therapist's responsibility to:

Review the efficacy of the allocated arm support and change it if necessary. See pages 32-36 (green sheets).

Even if no changes are made, this should still be documented, signed and dated on the proforma.

Variance from the protocol:

Selecting the most appropriate arm support, monitoring its efficacy and gauging patient compliance is not always straightforward.

It is especially important, therefore, to document difficulties of this nature on the proforma. This will add to our understanding of these problems and ultimately improve patient care.

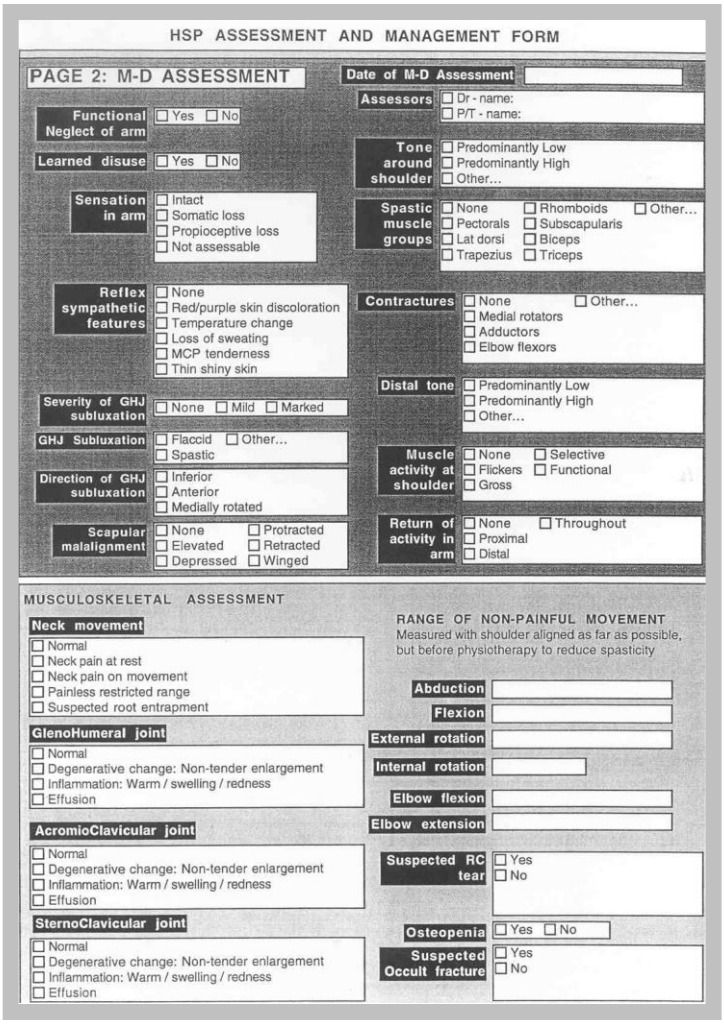
Categories on the M-D Assessment Form are clarified below and on the next page:

Range of non-painful movement: This test should be performed passively in sitting

Suspected rotator cuff tear: A rotator cuff tear may be suspected in a patient with some or all of the following features and may be confirmed by MRI scan:

- History of trauma to the hemiplegic shoulder
- Persistent low tone
- Large subluxation
- Persistent pain

HSP Assessment and Management Form Page 2: M-D Assessment



HSP ASSESSMENT AND MANAGEMENT FORM

PAGE 2: M-D ASSESSMENT

Date of M-D Assessment

Assessors: ☐ Dr - name: ☐ P/T - name:

Functional Neglect of arm: ☐ Yes ☐ No

Learned disuse: ☐ Yes ☐ No

Tone around shoulder: ☐ Predominantly Low ☐ Predominantly High ☐ Other...

Sensation in arm: ☐ Intact ☐ Somatic loss ☐ Propioceptive loss ☐ Not assessable

Spastic muscle groups: ☐ None ☐ Rhomboids ☐ Other... ☐ Pectorals ☐ Subscapularis ☐ Lat dorsi ☐ Biceps ☐ Trapezius ☐ Triceps

Reflex sympathetic features: ☐ None ☐ Red/purple skin discoloration ☐ Temperature change ☐ Loss of sweating ☐ MCP tenderness ☐ Thin shiny skin

Contractures: ☐ None ☐ Other... ☐ Medial rotators ☐ Adductors ☐ Elbow flexors

Severity of GHJ subluxation: ☐ None ☐ Mild ☐ Marked

Distal tone: ☐ Predominantly Low ☐ Predominantly High ☐ Other...

GHJ Subluxation: ☐ Flaccid ☐ Other... ☐ Spastic

Muscle activity at shoulder: ☐ None ☐ Selective ☐ Flickers ☐ Functional ☐ Gross

Direction of GHJ subluxation: ☐ Inferior ☐ Anterior ☐ Medially rotated

Scapular malalignment: ☐ None ☐ Protracted ☐ Elevated ☐ Retracted ☐ Depressed ☐ Winged

Return of activity in arm: ☐ None ☐ Throughout ☐ Proximal ☐ Distal

MUSCULOSKELETAL ASSESSMENT

Neck movement: ☐ Normal ☐ Neck pain at rest ☐ Neck pain on movement ☐ Painless restricted range ☐ Suspected root entrapment

RANGE OF NON-PAINFUL MOVEMENT
Measured with shoulder aligned as far as possible, but before physiotherapy to reduce spasticity

Abduction
Flexion
External rotation
Internal rotation
Elbow flexion
Elbow extension

GlenoHumeral joint: ☐ Normal ☐ Degenerative change: Non-tender enlargement ☐ Inflammation: Warm / swelling / redness ☐ Effusion

AcromioClavicular joint: ☐ Normal ☐ Degenerative change: Non-tender enlargement ☐ Inflammation: Warm / swelling / redness ☐ Effusion

Suspected RC tear: ☐ Yes ☐ No

SternoClavicular joint: ☐ Normal ☐ Degenerative change: Non-tender enlargement ☐ Inflammation: Warm / swelling / redness ☐ Effusion

Osteopenia: ☐ Yes ☐ No

Suspected Occult fracture: ☐ Yes ☐ No

Functional neglect: May be seen clinically as failure to dress the arm, poor care of the arm, leaving it outside the wheelchair.

Learned non-use: May be seen clinically as activity that is present in the arm, but not used functionally by the patient.

Sensation in the arm: Assessment should include appreciation of light touch and ability to localise this, as well as joint position sense.

Light touch should be tested with the assessor's finger, proceeding from distal to proximal. The patient may localise verbally or by touching the assessed area.

Joint position sense should also be assessed from distal to proximal. The patient can be asked whether the thumb is being moved up or down, or to mirror the position of the hemiplegic limb with their sound side.

Gleno-humeral joint subluxation: The team must decide the dominant tonal picture at the glenohumeral joint. Only if it is a truly mixed picture should 'other' be ticked.

Direction of subluxation: This is assessed in relation to the normal anatomical position of the glenohumeral joint. The position for assessment is sitting; either unsupported or in a wheelchair, according to the patient's abilities.

Scapular malalignment: Malalignment is in relation to the normal anatomical position, NOT to the unaffected side. A winged presentation is best seen from a lateral view. Assessment should be in sitting.

Tone around the shoulder: This refers to the shoulder complex. Again the assessors must decide the dominant tonal picture.

Hypertonic (spastic) muscle groups: Do not confuse with soft-tissue shortening or contracture. This is asking for the neurological features of resistance to movement. To help you decide, consider whether resistance to movement changes with position or speed. This will not occur if resistance is due to mechanical shortening.

Contractures: This refers to soft-tissue adaptation and/or joint limitation i.e. the range of movement is not limited by tone. The end-feel of movement may be hard (bony) or soft (muscle/connective tissue). It is possible that patients will have components of mechanical and neurological restriction of movement.

Subsequent multi-disciplinary management and review

It is the doctor's, physiotherapist's and/or occupational t

Review management of patients on the ICP every fortnight until pa

This should be based on:

- Re-assessment of pain using the ShoulderQ, SPIN or seeking t
- Response to analgesic medication
- Response to therapeutic interventions
- Compliance with treatment
- A change in the nature/severity of hypotonia (flaccidity) or hyp
- A change in the alignment of the shoulder, such as subluxation
- A change in functional ability, for example, patients becoming

Northwick Park Hemiplegic Shoulder Pain Protocol

Subsequent Multi-disciplinary Review: Date…./…./….

Individual Review: P/T ……O/T……Date

Update Treatment Plan:
Hypotonic (Flaccid) shoulder - Have you considered FES?
Hypertonic (Spastic) shoulder – Have you considered Botox?

Update handling / support
What is current support system?
Is it appropriate / best available?
If not, what is recommended

NB: When pt gets on feet will need alternative support system

Medication review: Completing Doctor: …… Date ……..

Tick if done
☐ Shoulder Pain Questionnaire ☐ **Better** ☐ **Same** ☐ **Worse** ☐ **Resolved**

Pain control ☐**Satisfactory** ☐ **Not satisfactory**

Current medication for HSP:

Change of medication to:

Monitoring: FBC ☐ U+E ☐ LFTs ☐
Other……

Other intervention: eg Nerve Block /Botulinum Toxin
Details

9

Functional Electrical Stimulation (FES):

Patients with a persistently painful hypotonic (flaccid) subluxed shoulder should be considered for FES.

Botulinum Toxin

Patients with a persistently painful hypertonic (spastic) shoulder should be considered for Botox.

If either of these interventions are given, details should be noted on the proforma. If these interventions are not thought to be appropriate, please note the reason for this decision.

Ambulant patients

Patients often complain of an increase in their shoulder pain when they begin to walk, especially if they have a hypotonic (flaccid) shoulder.

Review of their arm support at this time is essential. The date when the patient starts walking and details of any change in arm support should be documented, signed and dated in the ***Individual Review*** section of the proforma.

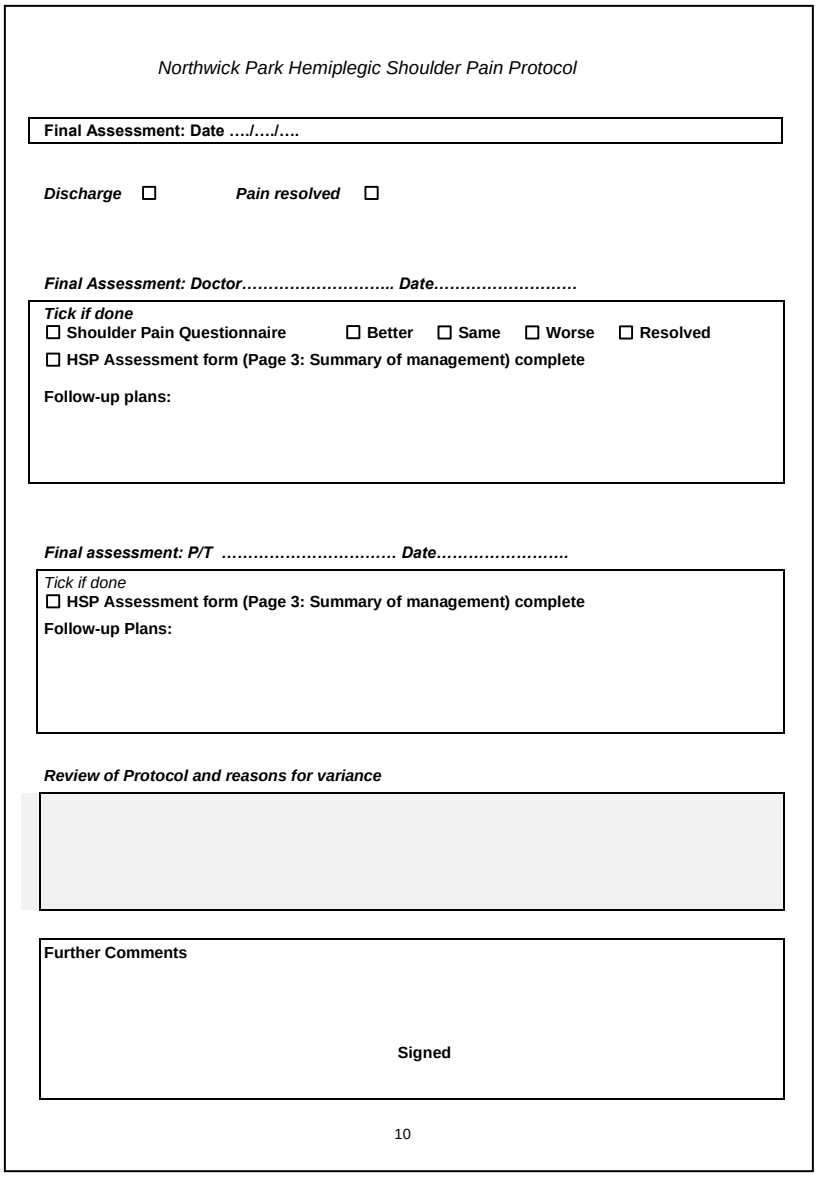
Final assessment

The ICP will come to an end when one of the following stages has been reached:

- The patient's shoulder pain has resolved
- The team are satisfied that the patient's shoulder pain is minimal and well managed
- The patient is at the point of discharge

It is the doctor's responsibility to:

Make a final evaluation of pain outcome. This may be informed by the patient's most recent ShoulderQ, SPIN recordings and/or team consensus. This information should be documented, signed and dated on the proforma.



Northwick Park Hemiplegic Shoulder Pain Protocol

Final Assessment: Date …./…./….

Discharge ☐ ***Pain resolved*** ☐

Final Assessment: Doctor…… Date……

Tick if done

☐ **Shoulder Pain Questionnaire** ☐ **Better** ☐ **Same** ☐ **Worse** ☐ **Resolved**

☐ **HSP Assessment form (Page 3: Summary of management) complete**

Follow-up plans:

Final assessment: P/T …… Date……

Tick if done

☐ **HSP Assessment form (Page 3: Summary of management) complete**

Follow-up Plans:

Review of Protocol and reasons for variance

Further Comments

Signed

10

It is the physiotherapist's responsibility to:

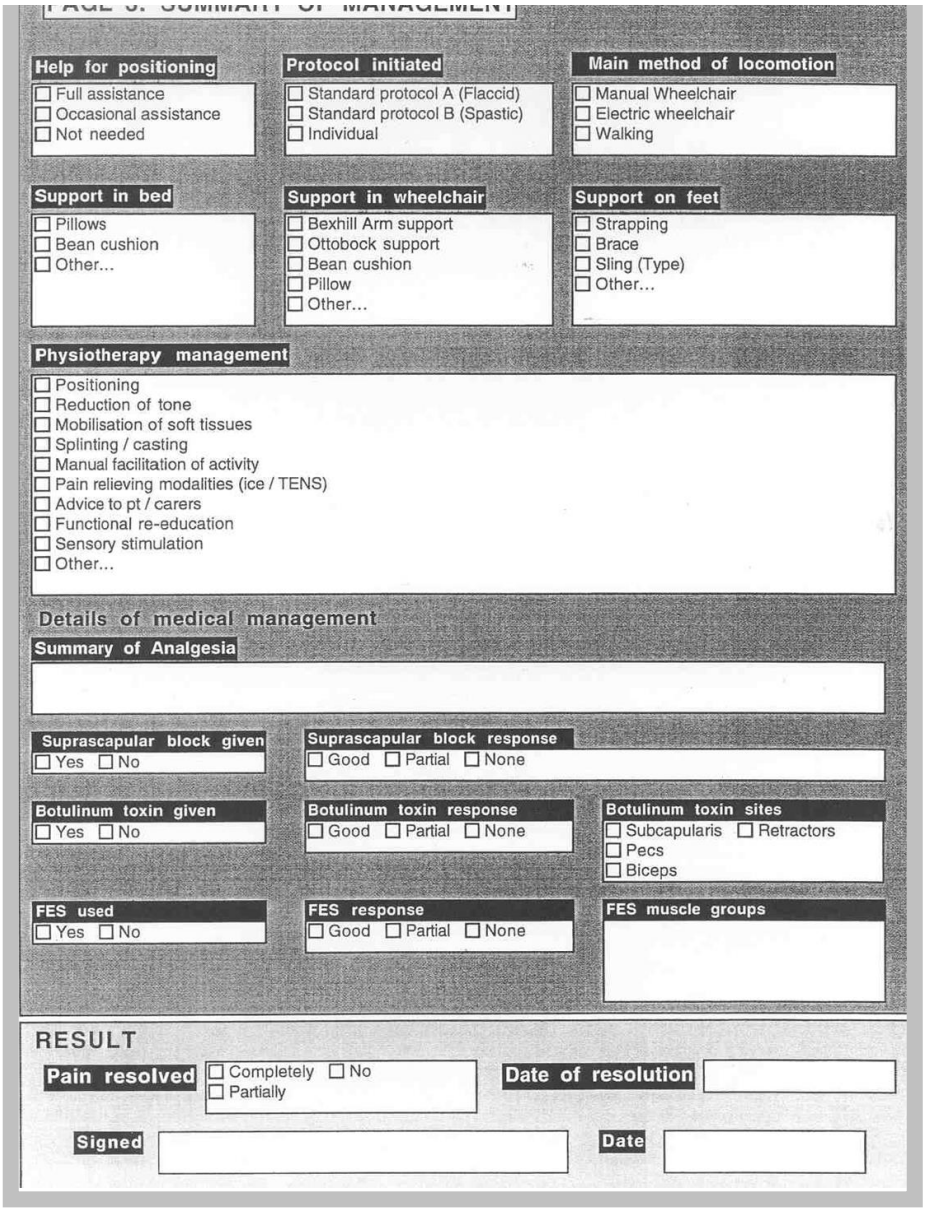
Summarise management while on the ICP by completing the ***HSP Assessment and Management Form – Page 3:*** (see page 17), signing and dating it.

This action should be documented, signed and dated on the proforma.

Comments about management that varied from recommendations in the sections on guidelines should be noted.

This information makes a useful contribution to the overall evaluation of the ICP.

HSP Assessment and Management Form
Page 3: Summary of Management



Help for positioning
- ☐ Full assistance
- ☐ Occasional assistance
- ☐ Not needed

Protocol initiated
- ☐ Standard protocol A (Flaccid)
- ☐ Standard protocol B (Spastic)
- ☐ Individual

Main method of locomotion
- ☐ Manual Wheelchair
- ☐ Electric wheelchair
- ☐ Walking

Support in bed
- ☐ Pillows
- ☐ Bean cushion
- ☐ Other...

Support in wheelchair
- ☐ Bexhill Arm support
- ☐ Ottobock support
- ☐ Bean cushion
- ☐ Pillow
- ☐ Other...

Support on feet
- ☐ Strapping
- ☐ Brace
- ☐ Sling (Type)
- ☐ Other...

Physiotherapy management
- ☐ Positioning
- ☐ Reduction of tone
- ☐ Mobilisation of soft tissues
- ☐ Splinting / casting
- ☐ Manual facilitation of activity
- ☐ Pain relieving modalities (ice / TENS)
- ☐ Advice to pt / carers
- ☐ Functional re-education
- ☐ Sensory stimulation
- ☐ Other...

Details of medical management

Summary of Analgesia

Suprascapular block given
☐ Yes ☐ No

Suprascapular block response
☐ Good ☐ Partial ☐ None

Botulinum toxin given
☐ Yes ☐ No

Botulinum toxin response
☐ Good ☐ Partial ☐ None

Botulinum toxin sites
- ☐ Subcapularis ☐ Retractors
- ☐ Pecs
- ☐ Biceps

FES used
☐ Yes ☐ No

FES response
☐ Good ☐ Partial ☐ None

FES muscle groups

RESULT

Pain resolved ☐ Completely ☐ No ☐ Partially

Date of resolution

Signed

Date