

Orthopaedic Evaluation Form

Surgery/Diagnosis:	Date of Surgery:
Assessment Date:	Start Time: _____ End Time: _____

History of Present Condition

Past Medical History/Co-morbidities

Vital Signs

HR	BP	SpO ₂	RR	T
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Medication: _____ Special Investigations: _____

Subjective: _____

Patient Starting Position: _____

Attachments (tick)

IV lines	A-line	Portovac drain	Calf Pumps	Urinary catheter	Other
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Incision/Wounds: _____ Joint ROM: _____

Signs of Infection: ☐ Yes ☐ No Sensation: _____

Glasgow Coma Scale: /15 Muscle Strength: ULs T LLs

Posture: _____ ICU Mobility Scale (0-10): _____

Auscultation	
BS	AS

Highest Level of Function: _____

Cough						
Strong/Weak			Productive/Unproductive			
Treatment Details						
IPPB	Spiro	DBE	PEEP	Manual CPT	Tx Exp Exs	Mobilisation-Details
AROM exs	AAROM exs	PROM	Bed exs	Other		
HR	BP	SpO ₂	R R	T		



Patient Sticker

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Post Treatment Vitals

Physio Name: _____