

## OSTEOARTHRITIS – PATIENT ASSESSMENT FOLLOW-UP

This Optional Decision Support Tool pertains to the Guideline:  
*Osteoarthritis in Peripheral Joints – Diagnosis and Treatment*  
www.BCGuidelines.ca

<b>Pain</b>											
Satisfactory pain control	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
Night pain affecting sleep	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
Overall pain rating (0= none; 10= most)	<input style="width: 60px; height: 20px;" type="text"/>										
<b>Satisfaction with Function</b>											
Walking	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
Interference with activities of daily living (ADLs or IADLs)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
Work	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
Recreation	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
<b>Patient Education</b>											
Self-management completed	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
Weight loss/diet plan needed	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
Joint protection	<input type="checkbox"/>	yes	<input type="checkbox"/>	no							
<b>Rehabilitation and Exercise</b>											
	<b>Tolerated</b>		<b>Effective</b>		<b>Change plan</b>						
Home exercise program	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Community exercise program	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Physical therapy for ROM and strengthening	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Medical devices	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
<b>Orthotics and Aids</b>											
	<b>Tried</b>		<b>Suitable</b>								
Orthotics	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Cane/walker	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Raised seats/devices	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
<b>Medications for OA (names, doses and side effects)</b>											
	<b>Tolerated</b>		<b>Effective</b>		<b>Change plan</b>						
Acetaminophen	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
NSAIDs	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Gastro protection	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Cox-2 inhibitor	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Opiates	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
Injectibles	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	yes	<input type="checkbox"/>	no			
<b>Referrals</b>											
Surgical	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="checkbox"/>	N/A	Urgent?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Other (indicate):											