MyoPro Clinical Evaluation

Patient Information

Patient Name:	
Date of Birth:	**Sex:**
Height (ft/in):	**Weight (lbs):**
Insurance Type:	**Date of Clinical Eval:**

History of Arm Weakness	
Primary Diagnosis:	**Date of Onset:**
Affected Side: ☐ Right ☐ Left ☐ Bilateral	**Hand Dominance:** ☐ R ☐ L ☐ Ambidextrous
Referring Physician (If known) - Name, Facility name & address, phone #'s**:**	

Patient History and Presentation *(This should include brief summary of the patient's med hx- age, dx, social hx, living situation, reason for MyoPro request.)*

Comorbidities (Check all that apply):

☐ Edema in the hand or arm
☐ Diabetes Mellitus
☐ Osteoporosis with a history of fracture – **Describe:**_____
☐ Other neuromuscular conditions other than primary Dx:_____
☐ Other conditions or factors that may impact MyoPro use (cancer DX/treatments, obesity etc.):
Please specify:_____

Additional Information:

Does the patient have vision issues? ☐ Yes ☐ No
If yes, please explain:_____
Does the patient have aphasia? ☐ Yes ☐ No ☐ Expressive ☐ Receptive ☐ Both
Does the patient have neglect of extremity? ☐ Yes ☐ No If yes, ☐ Right ☐ Left
If yes, please explain:_____
Does the patient have any skin or metal allergies? ☐ Yes ☐ No
If yes, please explain:_____
Were others present at the appt? ☐ Yes ☐ No
Spouse ☐ Other Family Member ☐ Friend ☐ Hired Caregiver ☐ Therapist ☐
Frequency of Support (hours/day & days/week) _____ & _____

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Mobility Status:

Ambulatory? (Can walk the distance of a room with/without a mobility device) ☐ Yes ☐ No

Wheelchair Dependent? ☐ Yes ☐ No **If yes:** ☐ MWC ☐ PWC

Transfer from one surface to another independently? ☐ Yes ☐ No

Describe patient's mobility status (e.g., uses a cane, walker, power WC, manual WC):

Home Environment:

☐ Lives alone ☐ Lives alone but has a caregiver come into the home ☐ Lives with others

☐ Requires assistance for transfers ☐ Requires assistance for basic ADLs

Additional notes:

Is there Wifi or access to internet at home? ☐ Yes ☐ No ☐ No, but will use phone for internet

Cognition: (Alert & Oriented: Person, Place, Time/date, Situation/Event)

A&O X 4 ☐ Person ☐ Place ☐ Year/Month/Day/Date ☐ Situation/Event ☐

A&O X 3 ☐ Person ☐ Place ☐ Year/Month/Day/Date ☐ Situation/Event ☐

Additional notes:

Have you received outpatient OT or PT in the last year? ☐ Yes ☐ No

Does the patient have a therapy referral? ☐ Yes ☐ No ☐ Unknown

If yes, name of facility, therapist name, phone #'s & email addresses:

Physical Exam

Resting Position (Check all that apply):	
Shoulder	☐ Neutral ☐ Flexed ☐ Extended ☐ Internal Rotation ☐ External Rotation
Elbow	☐ Flexed ☐ Extended
Forearm	☐ Neutral ☐ Pronated ☐ Supinated
Wrist	☐ Neutral ☐ Flexed ☐ Extended ☐ Ulnar Deviation ☐ Radial Deviation
Hand	☐ Neutral ☐ Flexed ☐ Extended
Additional notes (e.g., any atypical anatomical features/deformities):	

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Shoulder Subluxation
☐ No subluxation ☐ 1 Finger Width ☐ 2 Finger Widths ☐ 3 Finger Widths ☐ Fully Dislocated
Additional notes:

Pain Level (Upper Extremity)
Level of Pain 0-10 (0, No pain – 10, Worst Possible Pain):
Additional notes (e.g., chronic, intermittent, remedies):

Passive Range of Motion (PROM)°

	Shoulder		**Elbow**		**Wrist**		**Fingers**	
	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL
Flexion								
Extension								
Abduction								
Adduction								

*WNL = Within Normal Limits, does not require detailed measurements

Additional notes:

Active Range of Motion (AROM)°

	Shoulder		**Elbow**		**Wrist**	
	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL
Flexion						
Extension						
Abduction						

*WNL = Within Normal Limits, does not require detailed measurements

Additional notes:

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Manual Muscle Testing/Active Range of Motion (AROM)	
Grade 5	Full AROM against gravity, and can fully hold that position against resistance
Grade 4	Full AROM against gravity, but buckles slowly against resistance
Grade 3	Full AROM against gravity, but buckles quickly against resistance (no weight bearing capacity)
Grade 2	Partial AROM against gravity, or partial-to-full ROM with gravity eliminated
Grade 1	No AROM, muscle twitch observed
Grade 0	No AROM, no muscle twitch

	Shoulder		**Elbow**		**Wrist**		**Fingers**	
	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL	Left ☐ WNL	Right ☐ WNL
Flexion	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5
Extension	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5	___ / 5
Abduction	___ / 5	___ / 5					___ / 5	___ / 5
Adduction	___ / 5	___ / 5					___ / 5	___ / 5

*WNL = Within Normal Limits, does not require detailed measurements

Additional notes:

Modified Ashworth Scale (MAS) Spasticity Score: Grade 0-4	
Grade	**Description**
0	No increase in muscle tone
1	Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end range of motion when the affected parties moved in flexion or extension
1+	Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder (less than half) of the range of motion
2	More marked increase in muscle tone through most of the range of motion, but the affected part is easily moved
3	Considerable increase in muscle tone, passive movement is difficult
4	Affected part is rigid in flexion or extension

Biceps:	**Triceps:**
Wrist/Finger Flexors:	**Wrist/Finger Extensors:**

Additional notes (Botox injections, using oral baclofen/other muscle relaxers):

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Nerve and Muscle Activity			
Patient demonstrates observable muscle activity over the following target muscle groups:			
☐ Biceps	☐ Triceps	☐ Forearm Flexors	☐ Forearm Extensors
EMG assessed via: ☐ MARK Unit	☐ Tethered device	☐ Not tested, explain below	
Additional notes:			

Clinical Requirements

Criteria (Please Check To Confirm):

Personal

☐ Intact cognition

☐ Highly motivated, appropriate goals

Shoulder

☐ Minimum active shoulder flexion >30° and abduction >20° (If not, can the patient accept function with elbow held down at the side?)

☐ Maximum shoulder subluxation of 2 finger widths

☐ No uncontrolled shoulder pain

Elbow

☐ Adequate EMG signal in biceps or triceps

☐ Elbow, ipsilateral wrist and shoulder joints must be intact

☐ Elbow joint cannot be dislocated

☐ Minimal passive range of motion from –30° extension to 110° flexion, without pain (If existing contractures prevent this, seek guidance about interventions to resolve before fitting)

☐ None to moderate elbow flexor/extensor tone ≤ 3 M.A.S.

☐ If using Botox, patient understands this drug can be useful for pre-fitting spasticity reduction, but may interfere with MyoPro function if continued long term after fitting

Wrist/Fingers (for Motion G only)

☐ Adequate EMG signal in wrist/hand flexor or extensor groups

☐ Passive range of wrist to neutral while fingers in extension, without pain

☐ None to mild flexor/extensor tone ≤ 2 M.A.S.

☐ If using Botox, patient understands this drug can be useful for pre-fitting spasticity reduction, but may interfere with MyoPro function if continued long term after fitting

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Assessment and Plan

This patient is recommended for:	
Side:	☐ Left only ☐ Right only ☐ Bilateral (requires manager approval)
Type:	☐ Motion G (Powered upper extremity range of motion assist device, elbow, wrist, hand, finger, single or double upright(s), includes microprocess, sensors, all components and accessories custom fabricated) ☐ Motion W (Powered upper extremity range of motion assist device, elbow, wrist, hand, single or double upright(s), includes microprocessor, sensors, all components and accessories custom fabricated)
If this patient does not qualify for any MyoPro, do you recommend re-evaluation? ☐ No ☐ Yes, when to re-evaluate?:_____	
Please write below, or attach, any additional comments or recommendations you have regarding the candidacy of this individual:	

By signing, you certify that either the patient meets the required inclusion criteria or that you have discussed any fit limitations and cautions with the patient, and you and the patient agree any limitations are acceptable.	
Signature:	Date:
Clinician Printed Name (including credentials):	
Company:	
Address:	
Phone Number:	
Clinician Email:	
Evaluation Type: ☐ Telehealth ☐ In-Person	

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