1. Upper Extremity (Must be seen within 3-4 weeks post injury and be treated for up to 12 weeks)
    i. rotator cuff tendonitis
    ii. impingement/bursitis
    iii. lateral epicondylitis
    iv. carpal tunnel syndrome
2. Before the start of a treatment plan, ask your patient to give their informed consent by signing the attached form (a copy should be provided to them and an original copy should be kept in their chart).
3. Next ask your patient to complete the initial patient outcome survey.
4. Please try to include evidence based treatments in your treatment plan:

	Supported by Evidence	Not Supported by Evidence
Carpal Tunnel Syndrome (CTS)	- Manipulation - Mobilization - Night splinting - Ultrasound	- Acupuncture - Braces - Full time splinting - Laser - Magnets - Nerve gliding exercises
Lateral Epicondylitis (LE)	- Acupuncture - Exercises - Manipulation - Mobilization - Ultrasound	- Ionization - Laser - Pulsed electromagnetic field - Rebox
Rotator Cuff Injury (RCI)	- Massage - Mobilization	- Acupuncture - Electromagnetic therapy - Electrotherapy - Laser - Needle aspiration - Shockwave therapy

5. After you have completed your treatment plan (after a maximum of 12 weeks) ask your patient to complete the second (identical) patient outcome survey.
6. Finally complete the discharge report and submit the entire package to the OATA TPI Committee via one of the following methods:
    a. Scanning and e-mailing it to atdatacollection@gmail.com
    b. Mailing it via Canada Post:
    OATA Data Collection Project
    140 Allstate Parkway, Suite 302
    Markham ON L3R 5Y8

Informed Consent
Ontario Athletic Therapists Association Demonstration Project

You are being asked to participate in a research study. In order to be able to make an informed decision on whether or not you want to participate in this project, you should understand what the project aims to accomplish, as well as the possible risks and benefits of participation. This form describes the purpose, procedures, possible benefits, and risks associated with the research at hand. The form also explains how the personal information of participants will be used and protected. Once you have read and understood the information in this form and your questions about the study have been answered, you will be asked to sign the form if you wish to participate. Ensure that you receive a copy of this document to take with you.

Explanation of Study

This study is being conducted in order to collect patient outcome results for specific injures using evidence based treatment in a format familiar to public and private payers.

If you agree to participate, you will be asked to complete intake and discharge questionnaires.

Risks and Discomforts

No risks or discomforts are anticipated

Benefits

This study is important in helping the Ontario Athletic Therapists Association expand coverage by providing extended health plans for Athletic Therapy.

Confidentiality and Records

Your personal information will not be publicly known and any identifying information that could link any of the data to you will be kept strictly confidential.

Compensation

No compensation will be provided.

Contact Information

If you have any questions regarding this study, please contact:
Michael Robinson CAT(C) ATC
mike@robinsonmike.com 647-964-9660

By signing below, you are agreeing that:

- you have read this consent form (or it has been read to you) and you have been given the opportunity to ask questions and have them answered;
- you have been informed of potential risks and they have been explained to your satisfaction;
- you are 18 years of age or older;
- your participation in this research is completely voluntary;
- you may leave the study at any time; if you decide to stop participating in the study, there will be no penalty to you, you will not lose any benefits to which you are otherwise entitled and the current care you are receiving will not change in any way.

Signature_____ Date_____

Printed Name_____

THE QuickDASH OUTCOME MEASURE

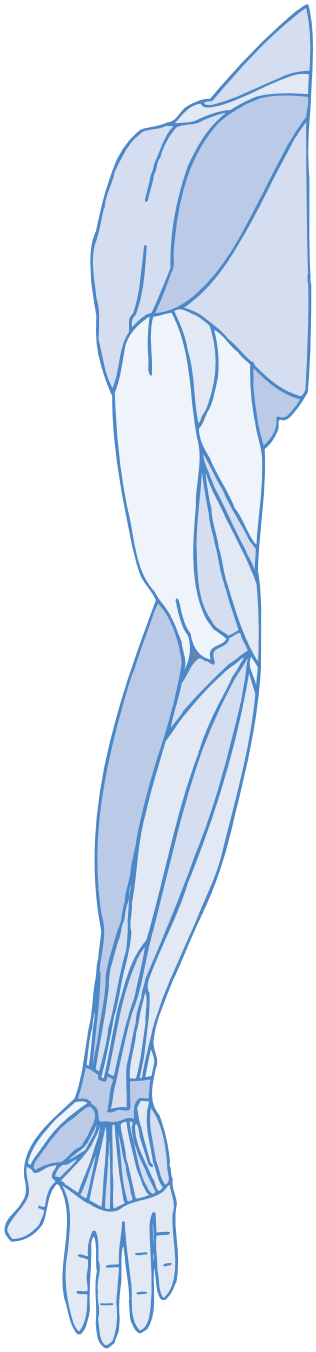
INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your *best estimate* of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.



*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is:_____

❒ I do not work. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for your work?	1	2	3	4	5
2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you:_____

❒ I do not play a sport or an instrument. (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

THE QuickDASH OUTCOME MEASURE

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer *every question*, based on your condition in the last week, by circling the appropriate number.

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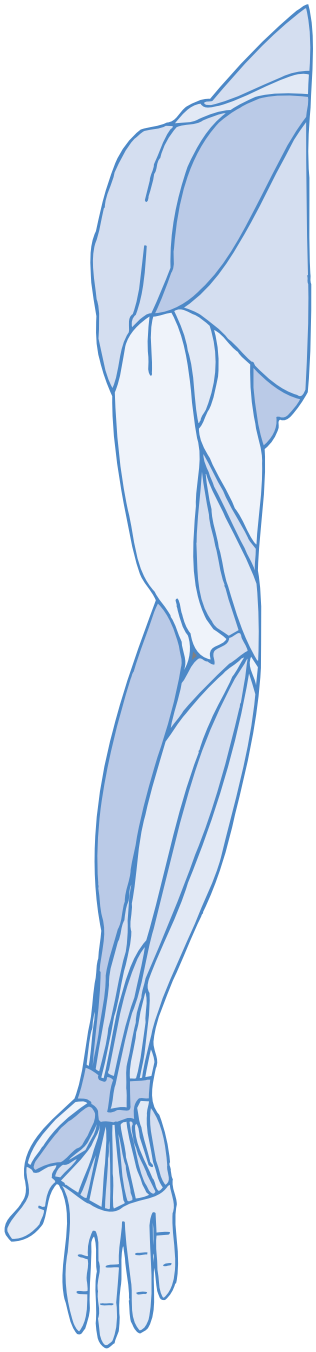

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
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2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
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10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

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2. doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. doing your work as well as you would like?	1	2	3	4	5
4. spending your usual amount of time doing your work?	1	2	3	4	5

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Please circle the number that best describes your physical ability in the past week.

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2. playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. spending your usual amount of time practising or playing your instrument or sport?	1	2	3	4	5

SCORING THE OPTIONAL MODULES: Add up assigned values for each response; divide by 4 (number of items); subtract 1; multiply by 25.
An optional module score may <u>not</u> be calculated if there are any missing items.

OATA

For internal use only

Form identification no. _____

Upper Extremity Injuries Discharge Report

A. Patient Demographics

Practitioner Identification No.: _____ Patient Identification No.: _____
(Please provide a random patient identifier number)

1. Gender: ☐ Male ☐ Female

2. Age Group: ☐ 0-14 ☐ 15 – 24 ☐ 25 – 34 ☐ 35 – 44 ☐ 45-54 ☐ 55-64 ☐ 65+

B. Clinical Information

3. (a) Patient completed Program of Care: ☐ Yes or (b) Patient did not return/self-discharged from Program of Care: ☐ Yes

4. (a) Specify date of first visit: mm | dd | yyyy

   (b) Specify date of last visit: mm | dd | yyyy

5. Please select one injury:

Carpal Tunnel Syndrome	☐ Left	☐ Right
Lateral Epicondylitis	☐ Left	☐ Right
Rotator Cuff Injury	☐ Left	☐ Right

6. (a) Summary of physical findings at discharge:

   (b) Summary of significant changes from initial assessment:

7. Describe any changes in health status (e.g. changes in medication type or dosage):

8. (a) At Assessment

   Indicate nature of patient's pain (choose all that apply):

☐ Pain in shoulder
☐ Numb, tingling sensation over hand and into fingers
☐ Other (please specify)
☐ Pain in wrist or hand
☐ Pain lateral elbow
☐ Shooting pain, forearm and hand

(b) At Discharge

Indicate nature of patient's pain (choose all that apply):

☐ Pain in shoulder
☐ Numb, tingling sensation over hand and into fingers
☐ Other (please specify)
☐ Pain in wrist or hand
☐ Pain lateral elbow
☐ Shooting pain, forearm and hand

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Upper Extremity Injuries Discharge Report

9. (a) At Assessment

Describe patient's limitations in Activities of Daily Living:

☐ Self-care ☐ Sports/Leisure activities ☐ Child care ☐ Hobbies
☐ Sleep disturbance ☐ Housekeeping ☐ Other (please specify)

(b) At Discharge

Describe patient's limitations in Activities of Daily Living:

☐ Self-care ☐ Sports/Leisure activities ☐ Child care ☐ Hobbies
☐ Sleep disturbance ☐ Housekeeping ☐ Other (please specify)

10. (a) At Assessment

Record QuickDASH scores:
QuickDASH Disability/Symptom Score: _____ QuickDASH Work Module Score: _____

(b) At Discharge

Record QuickDASH scores:
QuickDASH Disability/Symptom Score: _____ QuickDASH Work Module Score: _____

11. Has the patient physically returned to pre-injury level of overall function? ☐ Yes ☐ No

12. Are there any complicating factors (yellow flags) that may delay recovery? ☐ Yes ☐ No

If yes, please specify:

☐ Believes hurt equals harm ☐ Home environment concerns ☐ Prefers passive treatments
☐ Fears/avoids activity ☐ Low mood/social withdrawal ☐ Other (please specify)

13. Please indicate if any of the following are required:

Additional treatments	Yes ☐	☐ No	
Additional re-assessments	Yes ☐	☐ No	
Referrals	Yes ☐	☐ No	If yes, to whom were the referrals made? (e.g. other health professionals) [Do not provide names]

C. Summary of Care Delivered

Program of Care Interventions Supported by Evidence — Program Weeks

14. Please indicate Program of Care component delivered:

		Weeks 1-6	Weeks 7-12
(a) Carpal Tunnel Syndrome (CTS)	Manipulation	☐	☐
	Mobilization	☐	☐
	Night splinting	☐	☐
	Ultrasound	☐	☐

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Upper Extremity Injuries Discharge Report

(b) Lateral Epicondylitis (LE)	Acupuncture	☐	☐
	Exercises	☐	☐
	Manipulation	☐	☐
	Mobilization	☐	☐
	Ultrasound	☐	☐
(c) Rotator Cuff Injury (RCI)	Exercises	☐	☐
	Massage	☐	☐
	Mobilization	☐	☐

Program of Care Interventions Not Supported by Evidence and Not Recommended

15. Please indicate Program of Care component delivered:

	Program Weeks	
	Weeks 1-6	Weeks 7-12
Acupuncture (CTS, RCI)	☐	☐
Braces (CTS)	☐	☐
Electromagnetic therapy (RCI)	☐	☐
Electrotherapy (RCI)	☐	☐
Full time splinting (CTS)	☐	☐
Ionization (LE)	☐	☐
Laser (CTS, LE, RCI)	☐	☐
Magnets (CTS)	☐	☐
Needle aspiration (RCI)	☐	☐
Nerve gliding exercises (CTS)	☐	☐
Pulsed electromagnetic field (LE)	☐	☐
Rebox (LE)	☐	☐
Shockwave therapy (RCI)	☐	☐

16. Visits Summary

Total number of treatment visits during Program of Care: Weeks 1-6 ____ Weeks 7-12 ____

17. Total number of treatment visits: _____

Under no circumstances is private or confidential personal patient information to be disclosed to the OATA or third party.

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