

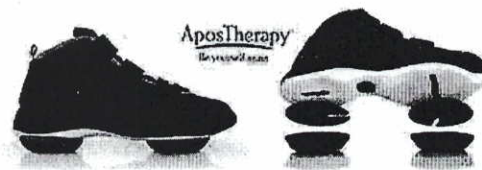


ProHealth & Fitness PT OT

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APOS CHECKLIST (inclusion criteria)

DATE: ___/___/___ PATIENT: _____ SOURCE: _____

Pts primary doctor: _____ Specialist Dr. _____

YES NO

Knee and/or Back appropriate diagnoses
○ List provided for each knee and/or back _____

Balance and Safety Clearance
○ No significant falls risk for APOS (can pt walk ~20' inside without holding on?)

Moderate or advanced knee/back issues
○ Chronic and persistent, not adequately/satisfactorily/totally controlled with conservative measures (i.e. rest, decreased activity, PT, injections)

Pain description
○ Location, onset, VAS, duration, character, aggravating, relieving factors

Conservative Measures including
○ Activity modification, or PT, exercise/classes, NSAIDs/meds, injections, weight loss efforts

Functional limitations – interfering with ADL
○ (mobility, toileting, grooming, dressing, bathing, and eating/food prep)

What is hard to do? _____

Provide Signature
Provider Name: _____

* Answering NO to any of the requirements above, deems the patient currently ineligible to receive APOS therapy. **All must be yes to be eligible**