Carbonhand Patient Screening

First name: _____ Date: _____

Last name: _____

Phone number: _____

1. Do you have reduced grip strength and/or impaired hand function?

- ☐ Yes, in one hand
- ☐ Yes, in both hands
- ☐ No

2. Can you make a full fist with or without assistance?

Left hand

- ☐ With assistance
- ☐ Without assistance

Right hand

- ☐ With assistance
- ☐ Without assistance

3. Can you initiate extension or opening your hand?

Left hand

- ☐ Yes
- ☐ No

Right hand

- ☐ Yes
- ☐ No

4. Does your hand open fully with or without assistance?

Left hand

- ☐ With assistance
- ☐ Without assistance

Right hand

- ☐ With assistance
- ☐ Without assistance

If not, how far will it open?

_____

BIOSERVO

5. Do you have spasticity?

Left hand	Right hand
☐ Yes	☐ Yes
☐ No	☐ No

If yes, describe.

_____

6. Do you have any hand pain?

Left hand	Right hand
☐ Yes	☐ Yes
☐ No	☐ No

If yes, please describe.

_____

7. Do you have any wounds on your hand?

Left hand	Right hand
☐ Yes	☐ Yes
☐ No	☐ No

8. Do you currently have a swollen hand or do you frequently have problems with swelling of the hand?

Left hand	Right hand
☐ Yes	☐ Yes
☐ No	☐ No

9. Please describe your arm- and shoulder function.

_____

10. Do you have intact sensory function of your hand?

Left hand	Right hand
☐ Yes	☐ Yes
☐ No	☐ No

11. What are certain activities you are challenged with that you would like to see Carbonhand assist with?

_____

12. What VA do you go to?

_____

13. Do you have any upcoming appointments?

- ☐ Yes
- ☐ No

14. Do you have an advocate within the VA that would support this device for you?

- ☐ Yes
- ☐ No