



NATIONAL SPINAL INJURY REFERRAL HOSPITAL

Off Lenana Road along Rose Avenue
P.O Box 20906-00202
Nairobi, Kenya



CLIENT SUMMARY ASSESSMENT FOR REHABILITATION

PART I: PATIENT DETAILS

Name:	
Age:	
Gender:	
Occupation:	
Marital status:	
Vocational/ Occupational interest	
Residence:	
Tel no:	
Next of Kin:	
Tel no:	
Referring facility:	
Tel no:	
NHIF Membership name:	
NHIF Membership number:	
NHIF active:	
Cash paying:	
Date of admission:	

PART II: MEDICAL HISTORY AND EXAMINATION

Date of injury:	
Level of spinal injury	
Cause of injury/History	
Surgery done (Date, procedure, facility where surgery was done, name and contact of surgeon, outcome)	
History of prior surgery	
Associated injuries	
Respiratory support (Did the patient require respiratory support at any time and what respiratory support was administered)	

Comorbidities	
Current medications (List drug name, dosage and frequency)	
Length of stay at referring facility	
Length of stay at home	
Bladder care (No catheter, indwelling catheter, suprapubic catheter, uridome)	
Bowel care (Diapers or timed evacuation)	
Feeding (Oral feeding, tube feeding, self-feeding or dependent feeding)	
Pressure injury (if present- grade, size and location)	
Prior complications (History of DVT/PE, Urinary retention, urethral injury, fecal compaction, Autonomic dysreflexia, chest infections, pressure injury, heterotopic ossification, joint immobility/ joint stiffness/Joint contractures)	
Drug or food allergies	
History of blood transfusion (blood product, amount administered, date administered, frequency, reason for administration)	
Family/Social History	

**SYSTEMIC EXAMINATION
CARDIOVASCULAR SYSTEM**

Heart rate	
Blood pressure	
Heart sounds	
Positive findings	

RESPIRATORY SYSTEM

Respiratory rate	
Breathing pattern	
Breath sounds	
Positive findings	

GIT

Abdominal wall appearance (scaphoid, distended)	
Bowel sounds	
Positive findings	

GUT

Suprapubic region (fullness, tenderness)	
Catheter in situ	
Positive findings	

NEUROLOGICAL SYSTEM

Mental status (Oriented in time, place and person)	
GCS	
Spinal reflexes	
Cranial nerves	
Positive findings	

Recommendation by Reviewing Medic:

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PART III

ASIA Classification	
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UPPER LIMB POWER GRADING

MUSCLE GROUP	RIGHT POWER (MRC grading)	LEFT POWER (MRC grading)
Shoulder adductors		
Shoulder abductors		
Shoulder elevators		
Shoulder depressors		
Elbow flexors		
Elbow extensors		
Wrist flexors		
Wrist extensors		
Hand Grip		
Hand Grasp		
Lateral key pinch		

LOWER LIMB POWER GRADING

MUSCLE GROUP	RIGHT POWER (MRC grading)	LEFT POWER (MRC grading)
Hip flexors		
Hip extensors		
Hip adductors		
Hip abductors		
Knee flexors		
Knee extensors		
Ankle dorsiflexors		
Ankle plantar flexors		
Hallux extensors		

SENSORY LEVEL	
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FIM™ Instrument

L E V E L S	7 Complete Independence (Timely, Safely)	NO HELPER		
	6 Modified Independence			
	Modified Dependence			
	5 Supervision (Subject = 100%+)			
	4 Minimal Assist (Subject = 75%+)	HELPER		
	3 Moderate Assist (Subject = 50%+)			
	Complete Dependence			
	2 Maximal Assist (Subject = 25%+)			
	1 Total Assist (Subject = less than 25%)			

	ADMISSION	DISCHARGE	FOLLOW-UP
Self-Care			
A. Eating	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
B. Grooming	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
C. Bathing	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
D. Dressing - Upper Body	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
E. Dressing - Lower Body	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
F. Toileting	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Sphincter Control			
G. Bladder Management	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
H. Bowel Management	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Transfers			
I. Bed, Chair, Wheelchair	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
J. Toilet	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
K. Tub, Shower	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Locomotion			
L. Walk/Wheelchair	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> W Walk C Wheelchair B Both	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> W Walk C Wheelchair B Both	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> W Walk C Wheelchair B Both
M. Stairs	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Motor Subtotal Score	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Communication			
N. Comprehension	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> A Auditory V Visual B Both	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> A Auditory V Visual B Both	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> A Auditory V Visual B Both
O. Expression	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> V Vocal N Nonvocal B Both	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> V Vocal N Nonvocal B Both	<input style="width: 100%; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> V Vocal N Nonvocal B Both
Social Cognition			
P. Social Interaction	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Q. Problem Solving	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
R. Memory	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Cognitive Subtotal Score	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
TOTAL FIM Score	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

NOTE: Leave no blanks: enter 1 if patient not testable due to risk.

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**PHYSIOTHERAPIST
RECOMMENDATION**

**OCCUPATIONAL THERAPIST
RECOMMENDATION**

ASIA CHART

Patient Name _____

Examiner Name _____ Date/Time of Exam _____



**STANDARD NEUROLOGICAL CLASSIFICATION
OF SPINAL CORD INJURY**



MOTOR

KEY MUSCLES
(scoring on reverse side)

- | | | | |
|----|--------------------------|--------------------------|--|
| | R | L | |
| C5 | <input type="checkbox"/> | <input type="checkbox"/> | Elbow flexors |
| C6 | <input type="checkbox"/> | <input type="checkbox"/> | Wrist extensors |
| C7 | <input type="checkbox"/> | <input type="checkbox"/> | Elbow extensors |
| C8 | <input type="checkbox"/> | <input type="checkbox"/> | Finger flexors (distal phalanx of middle finger) |
| T1 | <input type="checkbox"/> | <input type="checkbox"/> | Finger abductors (little finger) |

UPPER LIMB TOTAL + =
(MAXIMUM) (25) (25) (50)

Comments:

- | | | | |
|----|--------------------------|--------------------------|-----------------------|
| L2 | <input type="checkbox"/> | <input type="checkbox"/> | Hip flexors |
| L3 | <input type="checkbox"/> | <input type="checkbox"/> | Knee extensors |
| L4 | <input type="checkbox"/> | <input type="checkbox"/> | Ankle dorsiflexors |
| L5 | <input type="checkbox"/> | <input type="checkbox"/> | Long toe extensors |
| S1 | <input type="checkbox"/> | <input type="checkbox"/> | Ankle plantar flexors |

Voluntary anal contraction (Yes/No)

LOWER LIMB TOTAL + =
(MAXIMUM) (25) (25) (50)

	LIGHT TOUCH		PIN PRICK	
	R	L	R	L
C2				
C3				
C4				
C5				
C6				
C7				
C8				
T1				
T2				
T3				
T4				
T5				
T6				
T7				
T8				
T9				
T10				
T11				
T12				
L1				
L2				
L3				
L4				
L5				
S1				
S2				
S3				
S4-5				

TOTALS { + = } + =
(MAXIMUM) (56) (56) (56) (56)

Any anal sensation (Yes/No)

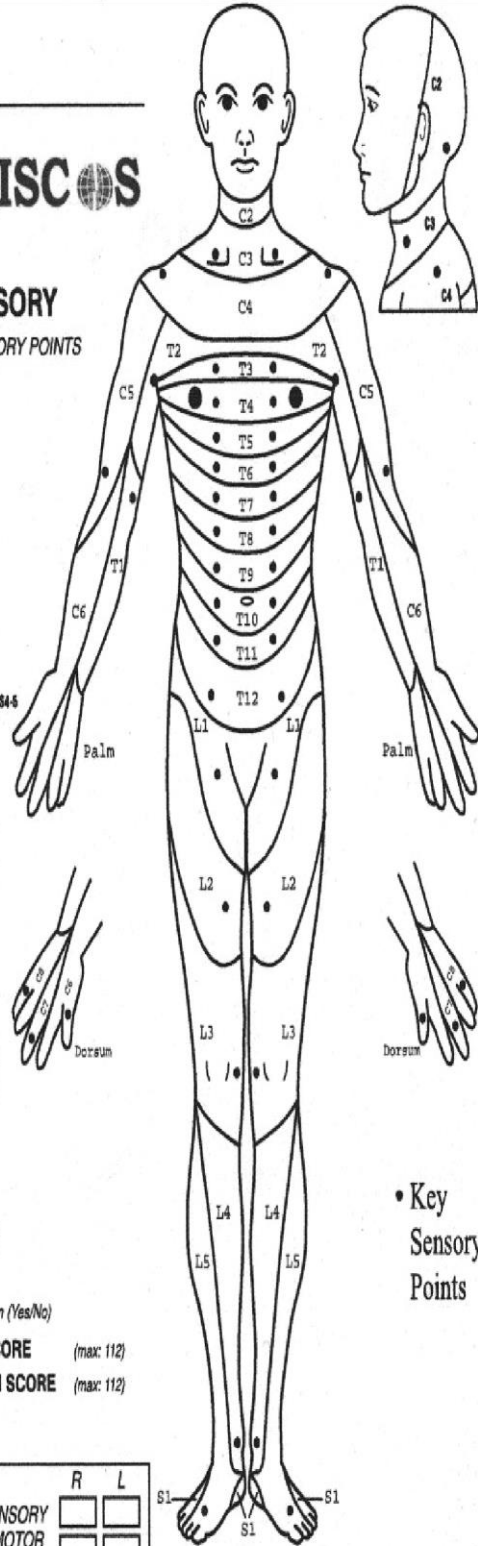
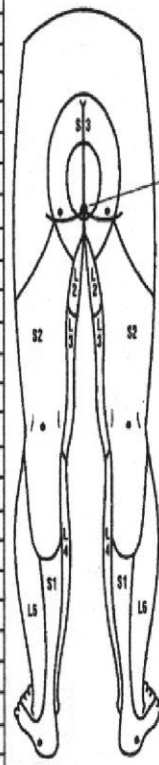
PIN PRICK SCORE (max: 112)

LIGHT TOUCH SCORE (max: 112)

SENSORY

KEY SENSORY POINTS

0 = absent
1 = impaired
2 = normal
NT = not testable



• Key Sensory Points

NEUROLOGICAL LEVEL <small>The most caudal segment with normal function</small>	SENSORY	R	L	COMPLETE OR INCOMPLETE? <small>Incomplete = Any sensory or motor function in S4-S5</small>	<input type="checkbox"/>	ZONE OF PARTIAL PRESERVATION <small>Caudal extent of partially innervated segments</small>	SENSORY	R	L
	MOTOR	<input type="checkbox"/>	<input type="checkbox"/>				MOTOR	<input type="checkbox"/>	<input type="checkbox"/>
ASIA IMPAIRMENT SCALE		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

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REV 03/06

PART IV

NUTRITION ASSESSMENT

ANTHROPOMETRIC MEASUREMENTS:

AGE	
WEIGHT (Kg)	
HEIGHT (m)	
BMI (Kg/m²)	

Category	BMI range- kg/m ²
Very severely underweight	Less than 15
Severely underweight	15.0 to 15.9
Underweight	16.0 to 18.5
Normal (healthy weight)	18.5 to 24.9
Overweight	25.0-29.9
Obese Class I (Moderately obese)	30.0 to 34.9
Obese Class II (Severely obese)	35.0 to 39.9
Obese Class III (Very severely obese)	Above 40

NUTRITION STATUS:

BIOCHEMICAL MEASUREMENTS

CLINICAL ASSESSMENT

OEDEMA	
MUSCLE WASTING	
PRESSURE SORE	

DIETARY

FOOD ALLERGIES/INTOLERANCE/RESTRICTIONS/DISLIKES/TABOOS

MILK/ DAIRY PRODUCTS	
FRUITS	

MEAT	
CHICKEN/EGGS	
FISH	
BREAD/CEREALS/ LEGUMES	
VEGETABLES	
FATS/OILS	
SALT/SUGAR	
WATER INTAKE	
OTHERS	

GI FUNCTION

APPETITE	INCREASED	NORMAL	SUPPRESSED
ANOREXIA			
VOMITING			
NAUSEA			
DIARRHEA			
CONSTIPATION			

MODE/METHOD OF FEEDING

ORAL	SELF	ASSISTED

TUBE FEEDING	
PARENTERAL	

NUTRITIONAL AND METABOLIC DISORDERS

NUTRITIONAL DISORDERS	
METABOLIC DISORDERS	

DIET PRESCRIPTION

NORMAL DIET	
MODIFIED DIET	
SUPPLEMENTATION	

Diet modification according to the patients nutritional status and diagnosis

NUTRITIONIST RECOMMENDATION

PART V

MENTAL HEALTH CHECK

Concentration/memory

- | | | |
|---------------------|-------------|---------------|
| 1. Memory | Intact..... | Impaired..... |
| 2. Immediate recall | Good..... | Poor..... |
| 3. Reversals. | Good..... | Poor..... |
| 4. Concentration | Good..... | Poor..... |

Judgement

Intact..... Impaired.....

If impaired,
describe.....
.....

Suicide/homicide

Ideation.....

Plans.....

Describe.....
.....
.....

Current and past drug/substance use (Indicate the frequency of use i.e. daily or occasional, duration of use and when one stopped)

Alcohol.....

Cigarettes.....

Miraa.....

Cannabis.....

Others

.....
.....
.....
.....
.....

Withdrawal symptoms experienced

.....
.....
.....
.....

Previous/current psychiatric illnesses

.....
.....
.....

Hallucinations, delusions and illusions present

.....
.....
.....

(Based on PHQ-9)

Over the last 2 weeks how often have you been bothered by any of the following problems	
Little interest or pleasure in doing things	
Feeling down, depressed or hopeless	
Trouble falling asleep, staying asleep or sleeping too much	
Feeling tired or having little energy	
Poor appetite or overeating	
Feeling bad about yourself, feeling that you are a failure, feeling that you have let yourself or your family down	
Trouble concentrating on things such as reading the newspaper, watching TV/Videos	
Speaking so slowly that other people have noticed	
Thinking that you would be better off dead	

0= Not at all 1=Several days 2= More than half the days 3= Nearly everyday

For an answer of 2 or 3 to any of the questions, a psychiatric consult should be requested

Socio-economic Assessment

Family support (rate from 0-10, 0 - no support and 10 - full support)

Spouse.....

Children

.....
.....
.....

Siblings

.....
.....
.....

Parents

Mother.....
 Father.....
 Others

 Place of resettlement (capture the route)

MENTAL HEALTH & SOCIAL WORKER RECOMMENDATION:

ASSISTIVE DEVICES REQUIRED (Attach prescriptions)

ORTHOPEdic TECHNOLOGIST RECOMMENDATIONS	
Wheelchair measurements	
AFO's	
Backslabs	
Other	

NURSING MANAGER RECOMMENDATION	NAME OF NURSING MANAGER
---------------------------------------	--------------------------------

REPORT COMPILED BY:	
FINAL RECOMMENDATION (give reasons based on admissions criteria and report for or against admission)	
TEAM PRESENT	NAME AND SIGNATURE
MEDICAL DOCTOR	
NURSE	
PHYSIOTHERAPIST	
OCCUPATIONAL THERAPIST	
ORTHOPEDIC TECHNOLOGIST	
PSYCHOLOGIST	
SOCIAL WORKER	
NUTRITIONIST	
RECORDS	
ACCOUNTS/NHIF	
ADMISSION PLAN:	Rehabilitation plan:
Surgical plan:	
Number of days to be admitted:	

Resettlement region:	
AUTHORIZED BY:	CHAIR PERSON HOSPITAL ADMISSIONS COMMITTEE

LIST OF RECOMMENDED ITEMS TO PURCHASE (Checklist)

Ripple mattress	
Gel Cushion	
Sheep's wool	
Knee pillows	
Wheelchair	
Backslabs	
AFO's	
Reacher	
Modification cuff	