LEXINGTON MEDICAL CENTER | Total Joint Replacement Program

MEDICAL EQUIPMENT AND HOME ENVIRONMENT QUESTIONNAIRE

Please complete this form and bring it to the total joint replacement class you will attend before your surgery. This will help your health care team plan for your discharge from the hospital.

Name:	**Date of Surgery:**

Type of Surgery:

1. Hip: ☐ Left ☐ Right
2. Knee: ☐ Left ☐ Right
3. Partial Knee: ☐ Left ☐ Right
4. Revision/Redo Hip: ☐ Left ☐ Right
5. Revision/Redo Knee: ☐ Left ☐ Right

Name of Person helping you after surgery:

Does anyone depend on you for care at home? ☐ Yes ☐ No

MEDICAL EQUIPMENT YOU CURRENTLY HAVE (PLEASE CHECK ALL THAT APPLY)

☐ Rolling Walker (wheels on front only)	☐ Rollator (walker with 4 wheels & seat)	☐ Standard Walker (no wheels)	☐ Cane
☐ Quad Cane (4 legs)	☐ 3-in-1 Commode Chair	☐ Bedside Commode	☐ Built-in High Toilet
☐ Wheel Chair	☐ Reacher	☐ Sock Aid	☐ Other _____

PLANNED DISCHARGE LOCATION

☐ Outpatient Rehab	☐ Home Health Preferred Home Health Agency (please specify)_____

FOR THERAPIST USE ONLY

Right Knee Extension:	Right Knee Flexion:
Left Knee Extension:	Left Knee Flexion:
Community Ambulator:	
Household Ambulator:	

Special Notes: _____

_____

_____

PLEASE RETURN THIS FORM TO THE TOTAL JOINT COORDINATOR AT THE END OF CLASS