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| --- | --- |
| Australian Government crest, Department of Veterans' Affairs branding | Knee Condition(s)Medical Impairment Assessment |
| Veteran |  | UIN |
|  |  |  |
|  |  |  |
| Please assess the following conditions:  |
|  |  |  |

1. Please complete either Table A **or** Table B in relation to the **Range of Movement (RoM)**.

**Table A:** Select the most accurate description of any loss of active RoM of the knees. (Consider motion in all planes with emphasis on those of functional importance.)

| **Description** | **Right** | **Left** |
| --- | --- | --- |
| **None or minor** restriction of movement. |[ ] [ ]
| Loss of about **one-quarter** range of movement. |[ ] [ ]
| Loss of about **half** range of movement. |[ ] [ ]
| Loss of about **three-quarters** range of movement. |[ ] [ ]
| Loss of **nearly all** movement / **ankylosis** in position of function. |[ ] [ ]
| **Ankylosis** in an **unfavourable position**, OR a **flail joint**. |[ ] [ ]

**Table B:** Enter the measured RoM in each plane.

| **Movement** | **Normal RoM** | **Right** | **Left** |
| --- | --- | --- | --- |
| Flexion. | 150° |  |  |
| Extension. | 0° |  |  |

1. Please select **all** that apply to any **joint replacement or realignments** undertaken for the condition(s) listed above.

| **Description** | **Right** | **Left** |
| --- | --- | --- |
| None. |[ ] [ ]
| Tibial osteotomy. |[ ] [ ]
| Partial knee replacement. |[ ] [ ]
| Total knee replacement. |[ ] [ ]

1. Please select **all** that apply.

| **Description** | **Yes** | **No** |
| --- | --- | --- |
| Genu varum with symptoms. |[ ] [ ]
| Genu valgum with symptoms. |[ ] [ ]

1. Please select the most accurate description of any **resting joint pain** (pain which is present in the absence of use of the joint, or which persists beyond the expected recovery period).

| **Description** | **Right** | **Left** |
| --- | --- | --- |
| None or **not usually present** at rest. |[ ] [ ]
| **Mild** pain that is **often present** at rest. |[ ] [ ]
| Pain that is **often** **present** at rest but **improves** after several hours or responds to medication or to therapeutic measures. |[ ] [ ]
| **Severe** pain that is **often present** at rest but **does not respond adequately** to medication or to therapeutic measures. |[ ] [ ]
| **Severe** pain that is **always present** at rest but **does not respond adequately** to medication or therapeutic measures AND **regularly interferes with sleep**. |[ ] [ ]

1. Please list **all conditions** contributing to the reported impairment to the **loss of ROM at Q1** and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

| **Condition** | **Contribution %** |
| --- | --- |
| e.g. Osteoarthritis of right knee joint  | 75% |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total** | **100%** |

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| --- | --- | --- | --- |
| Doctor's signature | Doctor's name | Date | Time to complete form |
|  |  |  |  |