WELLNESS CENTER AT RANCHO
RT200/300 FES Program
THERAPY PARTICIPATION FORM

Dear therapist,
Your patient, _____, would like to participate in Wellness Center at Rancho RT200/300 FES Training Program.
In order to participate, the following is **absolute criteria** (please place "x" next to all necessary criteria):
__Physical Therapy Evaluate and Treat order/Ordering Physician name:_____/Date of order:_____
__Hip, knee, ankle, shoulder, elbow, wrist joint range of motion adequate for use of the RT200/300
__Spasticity, if present, does not prevent user from easily pedaling on the RT200/300
__Pressure of spinal reflexes, residual sensory function, and residual motor function are identified.
__Setup for use (e.g. electrode placement, stimulation parameters, wheelchair setup) completed.
__Physiologic responses with use of RT300-SLSA are safe for continued use.

Does the patient have any **absolute contraindications**? If yes, patient is not eligible for use of RT200/300 device:
__Cardiac demand pacemaker
__Presence of unhealed or unstable fractures in lower/upper extremities
__Pregnancy
RT200/300 for upper extremity use only absolute contraindications:
__Grade three tear or greater of either rotator cuff
__Shoulder subluxation which cannot be corrected with electrically evoked contractions or other means such as a sling or taping
__Unhealed fractures in upper extremities, shoulder girdle, or upper ribs

Are there any **relative contraindications** present? (exceptions may be made based off of clinical judgement, or consult with PM&R physician if unsure)
__ Denervated muscle in lower/upper extremity muscles being stimulated
__Severe spasticity
__Heterotopic ossification causing severe limited range of motion
__Severe osteoporosis
__Dysesthesia Pain Syndrome
__open pressure sores or wounds over treatment area
__history of knee/hip/ankle/shoulder/elbow/wrist dislocation or subluxation; or implanted pins, screws, or other surgical hardware in last 3 months.
__implanted stimulators such as vagus nerve, phrenic, cardiac, cochlear, diaphragmatic stimulators with upper extremity FES
__malignancy

TO BE COMPLETED BY PARTICIPANT
I, _____, authorize my healthcare provider to release the following requested information to Rancho Los Amigos National Rehabilitation Center and to the Rancho Research Institute, Inc. for the purpose of participating in the "Wellness Center at Rancho"

_____ _____ _____ _____
Signature of Participant Date Signature of Guardian or Parent if a Minor Date

TO BE COMPLETED BY THERAPIST (Initial the appropriate line below):

Patient has **limitations** and is **not cleared** to participate. _____ (PT/OT initials)
Patient is **cleared** for the contraindications listed above and may participate in the Wellness Center at Rancho RT200/300 Training Program with these conditions:
Patient has **no limitations** to participation. _____ (PT/OT initials)
Patient has **limitations to participation**, however if patient adheres to these limitations, s/he is cleared to participate, limitations are as follows:_____
_____ (PT/OT initials)

RT200/300 Patient ID: __ __ __ __ __ __ __ (required)

_____ _____ _____ _____
PT/OT Name (Please print) **Phone Number** **PT/OT Signature** **Date**