WELLNESS CENTER AT RANCHO
Standing Frame Training Program
THERAPY PARTICIPATION FORM

Dear therapist,
Your patient, _____, would like to participate in Wellness Center at Rancho Standing Frame 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:_____
__SCI Fracture Risk Assessment Tool completed (if appropriate)
__Hip, knee, ankle, shoulder, elbow, wrist joint range of motion adequate for use of the standing frame
__Spasticity, if present, does not prevent user from using the standing frame
__Physiologic responses with use of the standing frame are safe for continued use
__patient weighs up to 280 lbs. for use of large Evolv EasyStand or up to 350 lbs. for use of XT EasyStand.

Does the patient have any **absolute contraindications**? If yes, patient is not eligible for use of standing frame device:
__Orthostatic Intolerance Syndrome (postural orthostatic hypotension)
__Impaired Skeletal Structure (osteoporosis, osteogenesis imperfecta, heterotopic ossification, any form of brittle bone disease)
__Severe upper or lower extremity contractures limiting appropriate positioning in stander or transfers to/from stander
__Hip Subluxation or other dislocated joints
__Unhealed truncal, pelvic, and/or lower extremity fractures
__Unstable vital signs
__Unresolved deep vein thrombosis
Are there any **relative contraindications** present? (exceptions may be made based off of clinical judgement, or consult with physician if unsure)
__Cognitive impairments or psychiatric conditions that may result in inability to follow directions
__Heterotopic ossification
__Orthostatic hypotension that resolves with rest, repositioning, and/or hydration
__Uncontrolled autonomic dysreflexia
__Severe cardiopulmonary disease
__Presence of lower extremity contractures
__"High" fracture risk, according to "Risk Factors for Lower Extremity Low-Trauma Fracture After SCI"

TO BE COMPLETED BY PARTICIPANT
I, _____, authorize my doctor 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 PHYSICAL THERAPIST (Initial the appropriate line below):

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

_____ _____ _____ _____
Physical Therapist's Name (Please print) **Phone Number** **Physical Therapist's Signature** **Date**