

Guidance for Physiotherapists on How to Complete the Patient Data Sheet

General Guidance:

The patient data sheet has been provided with an additional carbon copy. The purpose of this is to minimise the administration associated with project. It is anticipated that one version will be retained within the patient clinical notes and the other returned to the project office for data progressing. As we are using a carbon means of imprinting the information, can you please ensure that all information is recorded firmly to ensure that its transferred onto the underlying sheet. In order to minimise the time it takes to complete the sheet, the majority of answers require only a tick in the box adjacent to the relevant response. Only a couple of questions require you to note down a free text response.

Physiotherapists are encouraged to record any comments or issues they have on the **REVERSE** of the data sheet where there is plenty of available space and not add comments to the actual data sheet.

Assessment Information

The data fields below should be completed **AFTER** each patient has had their initial assessment. Some of the data items are self-explanatory i.e. gender, referral type, duration of symptoms etc.

For **GP referrals ONLY**, please record the **FIRST** date that the patient consulted their GP about their physiotherapy related problem which may be a different date to the referral to physiotherapy (i.e. GP may have tried some other form of management before referring the patient on).

Others data items are more fully explained within the table below

Data Item	Description																						
Duration of Symptoms	Indicate the period of time the patient has had their present symptoms and NOT the underlying or longstanding condition (e.g. a person may have been troubled on and off with LBP for a considerable time but we are only interested in for how long they have had their current exacerbation)																						
Employment Status	This should be self explanatory If the patient has been absent from paid work as a direct consequence of their physiotherapy related condition, please record the number of days they have been absent. For example, if a patient has been absent for 8 days the entry should read, 008 . Alternatively if the patient has been absent for 31 days it should read 031 . For those NOT absent or not in paid employment, please insert 000 in the box.																						
Condition Category	The abbreviations to be used include <table style="width: 100%; border: none;"> <tr> <td style="padding-left: 20px;">LBP</td> <td>Low Back Pain</td> </tr> <tr> <td style="padding-left: 20px;">Neck</td> <td>Neck Spinal Pain</td> </tr> <tr> <td style="padding-left: 20px;">Thoracic</td> <td>Thoracic Spinal Pain</td> </tr> <tr> <td style="padding-left: 20px;">Knee</td> <td>Any condition relating to the Knee</td> </tr> <tr> <td style="padding-left: 20px;">Lower Limb</td> <td>Any condition relating to the lower limb that does not Include 'knee' conditions</td> </tr> <tr> <td style="padding-left: 20px;">Upper Limb</td> <td>Any condition relating to the upper limb that does not Include 'shoulder' conditions</td> </tr> <tr> <td style="padding-left: 20px;">Shld</td> <td>Any condition relating to the shoulder</td> </tr> <tr> <td style="padding-left: 20px;">Neuro</td> <td>Any neurological condition</td> </tr> <tr> <td style="padding-left: 20px;">Urolog</td> <td>Any Urological condition</td> </tr> <tr> <td style="padding-left: 20px;">Multi</td> <td>Where more than one body area is referred for treatment at the same time i.e. LBP and LL</td> </tr> <tr> <td style="padding-left: 20px;">Other</td> <td>any condition not included above – please provide details</td> </tr> </table>	LBP	Low Back Pain	Neck	Neck Spinal Pain	Thoracic	Thoracic Spinal Pain	Knee	Any condition relating to the Knee	Lower Limb	Any condition relating to the lower limb that does not Include 'knee' conditions	Upper Limb	Any condition relating to the upper limb that does not Include 'shoulder' conditions	Shld	Any condition relating to the shoulder	Neuro	Any neurological condition	Urolog	Any Urological condition	Multi	Where more than one body area is referred for treatment at the same time i.e. LBP and LL	Other	any condition not included above – please provide details
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Severity	This relates to the severity of the presenting condition as determined by the physiotherapist following assessment. You are asked to classify the symptoms as being either: mild, moderate or severe. It would be useful for you to undertake some inter-rater reliability testing during the pilot stage with a couple of colleagues to ensure you are classifying patients similarly. (Further details available from the project team)
Previous Physio	This refers to previous physio FOR THE SAME CONDITION ONLY Indicate the patients status by circling wither Y or N and record the number of separate episodes
Subjective Severity of Condition - patient	Using the VAS provided, it is important that you ask each patient to complete the VAS IN THE SAME WAY . Ask the patient 'Please indicate on the scale how severe you feel your symptoms are affecting you, 0 means not at all and 10 means in the worst imaginable way' . Do not try to expand on this instruction, if necessary just repeat it not paraphrase Once the patient has made their mark, measure and record the score to the nearest 100 mm in the box provided. As before, if the reading is less than 10mm, e.g 8mm, this should be recorded as 008 in the box provided. Similarly a level of 51mm should be recorded 051

Discharge Information

Following the discharge /last visit of each patient, please complete the Discharge section of the data sheet. Some of the data is self explanatory i.e. date, other data items are explained in more detail below

Data Item	Description
Total no. of contacts	This refers to the total number of physiotherapy contacts contained within the full episode of care. Record only the number of contacts that you have with the patient on a face to face basis
Discharge Reason	Please see additional information provided
Outcome	Please see additional information provided This refers to the extent to which the patient has achieved the goals set for their treatment in the timescale predicted. A recording of 'Goals not recorded' should only be made when the patient FAILS to COMPLETE i.e. does not turn up for their last treatment visit
Patient Final Score	This involves repeating the VAS undertaken initially using the same method as described above on assessment. Ensure that the patient does not see their previous mark or know their score.
Drug and Test history	In order to examine the cost effectiveness of DA physio, we need to know about other drugs and tests the patient has had. This includes the three months up to their first physio contact and during the time they received treatment. Ask the patient if their GP had prescribed any drugs for them or tests that were as a consequence of their physiotherapy-related condition. Please record the response

There is the opportunity for you to record any additional comments on the reverse of the sheet

Physiotherapy Discharge Categories by Definition

<i>Discharge Reason</i>	<i>Definition</i>
Treatment Complete	Patient discharged by the physiotherapist with no indication for further physiotherapy treatment.
Failed to complete:	Patient failed to attend for last physiotherapy appointment and has not communicated with the service for a minimum of seven days.
Re-referred to other Health Care Practitioner	Further physiotherapy treatment not indicated, however, referral to other healthcare professional appropriate
Condition Resolved on Assessment:	At the initial physiotherapy contact, the presenting signs and symptoms have resolved to the extent where they do not require physiotherapy intervention.
Other	Patient discharged from physiotherapy due to a reason NOT described by any of the alternative categories, please record reason