

ProFHER TRIAL: PHYSIOTHERAPY TREATMENT LOG

Participant identification number:

Sheet number:

Please complete this form as soon as possible after each treatment session. Thank you.

| | Day | | Month | | Year | | Day | | Month | | Year | |
|---------------------------------|---|----------------------|-------|----------------------|----------------------|---|---|----------------------|-------|----------------------|----------------------|--|
| Date: | <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | |
| Location: | <input style="width: 100%;" type="text"/> | | | | | | <input style="width: 100%;" type="text"/> | | | | | |
| Name of person completing form: | <input style="width: 100%;" type="text"/> | | | | | | <input style="width: 100%;" type="text"/> | | | | | |
| Staff grade: | <input style="width: 100%;" type="text"/> | | | | | | <input style="width: 100%;" type="text"/> | | | | | |
| Session number: | <input style="width: 100%;" type="text"/> | | | | | | <input style="width: 100%;" type="text"/> | | | | | |
| Allocated time (mins): | <input style="width: 100%;" type="text"/> | | | | | | <input style="width: 100%;" type="text"/> | | | | | |
| Phase*: | <input style="width: 100%;" type="text"/> | | | | | | <input style="width: 100%;" type="text"/> | | | | | |

***Please see ProFHER physiotherapy protocol. Note: phase 3 starts after sling removal.**

Please record with a cross all that apply to the session:

| | | | |
|-------------------------|--------------------------|--|--------------------------|
| Advice and/or education | <input type="checkbox"/> | | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | | <input type="checkbox"/> |
| TENS | <input type="checkbox"/> | | <input type="checkbox"/> |
| Soft tissue techniques | <input type="checkbox"/> | | <input type="checkbox"/> |
| Joint mobilisations | <input type="checkbox"/> | | <input type="checkbox"/> |
| Stretching techniques | <input type="checkbox"/> | | <input type="checkbox"/> |
| Relaxation techniques | <input type="checkbox"/> | | <input type="checkbox"/> |
| Hydrotherapy | <input type="checkbox"/> | | <input type="checkbox"/> |

Other:
(Please specify)

Has the patient done their home exercises? Yes No (any comments*)

Yes No (any comments*)

Please record reasons below for any substantial difference from the ProFHER physiotherapy protocol.

Reasons (or comments*)

If **referral** to other speciality is required, please record speciality and reason

Please continue to complete the rest of this form overleaf for the next two sessions.

Please complete this form as soon as possible after each treatment session. Thank you.

| | | | | | | |
|---------------------------------|--------------------|-----------------|----------------|--------------------|-----------------|----------------|
| Date: | Day [][] | Month [][] | Year [][] | Day [][] | Month [][] | Year [][] |
| Location: | [][][][] | | | [][][][] | | |
| Name of person completing form: | [][][][][][] | | | [][][][][][] | | |
| Staff grade: | [][][][] | | | [][][][] | | |
| Session number: | [][][][] | | | [][][][] | | |
| Allocated time (mins): | [][][][] | | | [][][][] | | |
| Phase*: | [][][][] | | | [][][][] | | |

*Please see ProFHER physiotherapy protocol. Note: phase 3 starts after sling removal.

Please record with a cross all that apply to the session:

| | | |
|-------------------------|--------------------------|--------------------------|
| Advice and/or education | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| TENS | <input type="checkbox"/> | <input type="checkbox"/> |
| Soft tissue techniques | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint mobilisations | <input type="checkbox"/> | <input type="checkbox"/> |
| Stretching techniques | <input type="checkbox"/> | <input type="checkbox"/> |
| Relaxation techniques | <input type="checkbox"/> | <input type="checkbox"/> |
| Hydrotherapy | <input type="checkbox"/> | <input type="checkbox"/> |

| | | |
|----------------------------|--------------------------|--------------------------|
| Other: (Please specify) | [][][][][][][][] | [][][][][][][][] |
|----------------------------|--------------------------|--------------------------|

| | | | | |
|--|------------------------------|---|------------------------------|---|
| Has the patient done their home exercises? | <input type="checkbox"/> Yes | <input type="checkbox"/> No (any comments*) | <input type="checkbox"/> Yes | <input type="checkbox"/> No (any comments*) |
|--|------------------------------|---|------------------------------|---|

Please record reasons below for any substantial difference from the ProFHER physiotherapy protocol.

| | | |
|------------------------|--------------------------------|--------------------------------|
| Reasons (or comments*) | [][][][][][][][][][] | [][][][][][][][][][] |
|------------------------|--------------------------------|--------------------------------|

| | | |
|--|--------------------------------|--------------------------------|
| If referral to other speciality is required, please record speciality and reason | [][][][][][][][][][] | [][][][][][][][][][] |
|--|--------------------------------|--------------------------------|

Please continue to record treatment sessions on a new form once this form is complete. A separate form is available to record end of treatment options. Thank you very much for completing this form.