



INTENSIVE CLINICAL THERAPY PROGRAMME SCREEN

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PERSONAL INFORMATION

Name	
House number and street name	
Village/Town/City	
Country	
Postcode	
Email	
Daytime telephone	
Evening telephone	
Facsimile	
Date of stroke	
Side of body affected	
Date of birth	

EMERGENCY CONTACT INFORMATION *(Contact person in case of an emergency)*

If above address please leave blank

Name	
House number and street	
Village/Town/City	
Country	
Postcode	
Daytime telephone	
Evening telephone	
Relationship to above	

MEDICAL STATUS

Do you suffer from the following medical conditions? Yes or No

Heart disease	
Hypertension	
Diabetes	
Epilepsy	
Severe chronic arm pain	
Finger Joint deformities	
Any other medical condition	
Drug History	

COGNITIVE STATUS

Can you perform the following? Yes or No

Follow instructions reliably	
Communicate reliably	

PHYSICAL STATUS

Can you perform the following? Yes or No

Transfer independently		
Independent with toileting		
Independent with sit to stand		
Stand for 5 minutes without a device (e.g. a stick)		
Can you passively open your fingers fully with your wrist straight?		
Raise your arm at the shoulder		If yes, how much?
Bend your elbow		If yes, how much?
Straighten your elbow		If yes, how much?
Open your hand		If yes, how much?
Close your hand from open		If yes, how much?

VIDEO ASSESSMENT

Please provide video footage of the following movements: (affected extremity)

1. raise arm straight in front of you as far up as you can
2. raise arm from the side as far up as you can
3. hand behind your head
4. hand behind your back
5. hand to mouth
6. attempt to grasp water bottle and drink
7. attempt to grasp/release tennis ball or small towel

Please return this signed form to the address listed below. We will review your information to determine if you are a candidate for the programme. Once we have reviewed your information, we will contact you by phone for further evaluation and discuss the programme in more detail.

Thank You,
Katherine Horafas OTR/L

Please sign below regarding the following:

The answers I provided on this form accurately describe my medical, physical, and cognitive status. If my status changes prior to my scheduled Saebø Arm Training Programme appointment, it is my responsibility to contact Artimelia Ltd. prior to the treatment and report my new condition to determine if I still meet the required criteria.

Signature or Authorized Signee	Date

Send form to:

Fax: +30 2106209576 Email: khorafas@saebø.com or kathyh@hol.gr