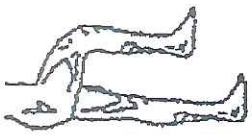
Knee Evaluation and KX Documentation for Ambulation

Patient Name: **Facility Name:**

Knee ROM



Moderate ROM

(__) Increase ROM
(__) Decrease Pain
(__) Gait Training
(__) Other
_____

Lt Thigh _____ Rt Thigh _____
Lt Patella _____ Rt Patella _____
Lt Calf _____ Rt Calf _____

Limited ROM

(__) Increase ROM
(__) Decrease Pain
(__) Gait Training
(__) Other
_____

Lt Thigh _____ Rt Thigh _____
Lt Patella _____ Rt Patella _____
Lt Calf _____ Rt Calf _____

Full ROM

(__) Increase ROM
(__) Decrease Pain
(__) Gait Training
(__) Other
_____

Lt Thigh _____ Rt Thigh _____
Lt Patella _____ Rt Patella _____
Lt Calf _____ Rt Calf _____

Goals/Measurements
(Circumference)

DXs

(__) Weight bearing-transfer
(__) Ambulating
(__) Knee Instability due to:
  (__) History of injury
  (__) Surgical Procedure related to:
  (__) Casting or Immobilization related to:

One or more of the following DX's:
(__) Rheumatoid Arthritis
(__) Osteoarthritis
(__) Chondromalacia
(__) Knee Ligamentous disruption
(__) Fracture of Femur
(__) Fracture of Tibia or Fibula
(__) Congenital deformity of knee
(__) Fracture Patella
(__) Dislocation of Knee
(__) Failed total knee arthroplasty
(__) Hyperextended Knee
(__) Multiple Sclerosis
(__) Hemiplegia, unspecified
(__) Paraplegia
(__) Obesity
(__) Pain
(__) Other _____
(__) Other _____

Ambulation Distance _____
_____

Assistive Devices _____
_____

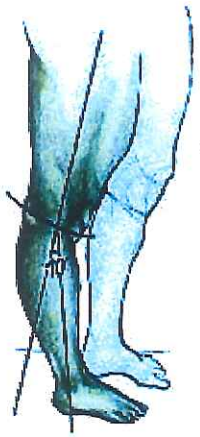
Notes / Tests

INSPECTION
- Gait
- Alignment
- Quadriceps atrophy
- Bruising
- Deformity

PALPATION
- Tibial tuberosity to the patella
- Bursae
- Joint lines
- Popliteal fossa
- Intra- and extra-articular swelling
  - Ballottement
  - Milking

RANGE OF MOTION
- Passive and active
  - Flexion
(normal = 130 to 150°)
  - Extension
(normal = 0 to -10°)
- Patella tracking

_____
_____
_____
_____
_____



Active hyperextension of knee >10°?

☐ NO
☐ YES
☐ *Left* ☐ *Right*

Notes: _____
_____

☐ **Knee Laxity** ☐ **Joint Laxity** ☐ **Prauer Test**

☐ **Lachman Test** ☐ **Valgus/Varus Stress Test**

☐ **Knee Buckling/Gait** **Date** _____

Therapist Print Name: _____ **Title:** _____

Therapist Signature: _____ **Date:** _____

Medicare Status: **Med A** ☐ **Med B** ☐
MDS / BD Name: _____

Physician Print Name: _____

Physician Signature: _____ **Date:** _____

Updated January 2023

PLEASE FAX WITH FACE SHEET TO (800) 603-3939