I.M.P.R.E.S.S. (Proximal Tibia)
Follow-up Clinical Assessment
To be completed by the PHYSICIAN

Directions: Answer every question by filling in the correct circle or writing in the information. If you need to change an answer, completely erase or cross out the incorrect mark, initial, and fill in the correct information. Mark only one answer for each question unless otherwise instructed. Shade circles like this: ●

Please answer questions 01-03 at one follow-up only.

01. Date of definitive surgery (MM/DD/YY)
   ___ / ___ / ___

02. Date of definitive wound closure (MM/DD/YY)
   ___ / ___ / ___

03a. Type of definitive wound closure (Mark all that apply)
   ○ Primary
   ○ STSG
   ○ Flap (Specify in 3b.)
   ○ VAC assisted

   b. If “Flap”, specify type
      ○ Local muscle
      ○ Fasciocutaneous
      ○ Free

04. Was CPM used?
   ○ Yes  ○ No

05. Surgical procedures performed since last follow-up
   ○ Yes  ○ No (Skip to question 7)

06. If “Yes”, specify procedure and date performed
   (Mark all that apply)

   a. Procedure
      ○ Bone graft
      ○ Dynamization
      ○ Exchange nail
      ○ Irrigation and debridement
      ○ Remove painful implant - nail
      ○ Remove painful implant – plate
      ○ Remove painful implant – screws only
      ○ Other (Specify below)

   b. Date
      (MM/DD/YY)
      ___ / ___ / ___

07. Complications since last follow-up
   ○ Yes (Complete Adverse Event Form)
   ○ No

Physical Exam

08a. Rotational alignment of affected extremity
   ○ Normal (Skip to question 09)
   ○ Internally rotated
   ○ Externally rotated

   b. If “Internally” or “Externally” rotated, specify
      degrees of rotation ___ ___

09a. Leg length discrepancy
   ○ None (Skip to question 10)
   ○ Affected leg shorter than unaffected leg
   ○ Affected leg longer than unaffected leg

   b. If “Short” or “Long”, specify discrepancy
      ___ ___ mm

For questions 10-13, fill in degree and either a positive (+) or negative (-) sign in the parenthesis.

10. Knee extension (0 = full extension, (+) = hyperextension)
   a. Active (     ) |       |       |       |
   b. Passive (     ) |       |       |       |

11. Knee flexion
   a. Active (     ) |       |       |       |
   b. Passive (     ) |       |       |       |

12. Ankle dorsiflexion (0 = neutral, (+) = dorsiflexion)
   a. Active (     ) |       |       |       |
   b. Passive (     ) |       |       |       |

13. Ankle plantarflexion
   a. Active (     ) |       |       |       |
   b. Passive (     ) |       |       |       |

14. Sensation at time of examination
   | Location | Normal | Diminished | Absent |
   |          |       |           |       |
   a. Superficial peroneal
   b. Deep peroneal nerve
   c. Posterior tibial nerve

Please continue on next page
**I.M.P.R.E.S.S.**  
*(Proximal Tibia)*  
**Follow-up Clinical Assessment**  
To be completed by the PHYSICIAN

<table>
<thead>
<tr>
<th>Muscle Group</th>
<th>Grade</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>a. Quadriceps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Ankle dorsiflexors</td>
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</table>

### 15. Manual muscle test

*Using the guide below mark the one grade that best applies to the muscle in question*

<table>
<thead>
<tr>
<th>Muscle Group</th>
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<th>0</th>
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<td></td>
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<tr>
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</tbody>
</table>

#### Manual Muscle Test

- **Grade 5:** Maximum resistance, full ROM
- **Grade 4:** Strong to moderate resistance, full ROM
- **Grade 3:** Full ROM against growth
- **Grade 2:** Gravity eliminated, full or partial ROM
- **Grade 1:** Gravity eliminated, muscles palpable
- **Grade 0:** Gravity eliminated, no contraction

### 16. Returned to pre-injury weight bearing status

- Yes
- No

### 17. How much weight bearing has the patient been doing in the last 2 weeks?

- Weight bearing prevented due to other injuries
- None
- 'Toe touch
- Partial weight bearing
- Full weight bearing as tolerated

### 18a. Recommended weight bearing status (Current visit)

- Weight bearing prevented due to other injuries
- None
- 'Toe touch
- Partial weight bearing (Specify below)
- Full weight bearing as tolerated

#### b. If “Partial weight bearing”, please specify

___ ___ ___ lbs

### 19. Recommended ambulatory support (Current visit)

- Unable to ambulate
- One crutch
- Walker
- Cane
- Two crutches
- None

### 20. On a scale from 0 to 10, mark the patient’s average level of pain at the fracture site/knee during weight bearing in the past week, with 0 being none and 10 being unbearable.

<table>
<thead>
<tr>
<th>Grade</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
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<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
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</tr>
</tbody>
</table>

### 21. On a scale from 0 to 10, mark the patient’s average level of pain during daily activities in the past week, with 0 being none and 10 being unbearable.

<table>
<thead>
<tr>
<th>Grade</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>7</th>
<th>8</th>
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<th>10</th>
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</thead>
<tbody>
<tr>
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<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>Unbearable</td>
</tr>
</tbody>
</table>

### 22. Frequency of pain medication use

- Never
- Less than once a week
- Once a week
- Several times a week
- Daily
- Multiple times per day

### 23a. Type of pain medications used (Mark all that apply)

- Acetaminophen
- Narcotics
- NSAIDs
- Other (Specify):

### 24. Patient’s Workers’ Compensation status

- Currently seeking Workers’ Compensation
- Workers’ Compensation case settled
- Not planning on applying for Workers’ Compensation

### 25. Patient’s litigation status

- Currently involved in litigation
- Litigation settled
- Not planning on pursuing litigation

### Radiographic Evaluation

#### 26. Alignment on post-operative films

- a. __ __ ° Varus or __ ° Valgus
- b. __ __ ° Anterior angulation or __ ° Posterior angulation

#### 27. Presence of callus

<table>
<thead>
<tr>
<th>Location</th>
<th>None</th>
<th>Some</th>
<th>Bridging</th>
<th>Remodeled</th>
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</thead>
<tbody>
<tr>
<td>a. Medial cortex</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
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<td>b. Lateral cortex</td>
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<td>o</td>
</tr>
<tr>
<td>c. Anterior cortex</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
<tr>
<td>d. Posterior cortex</td>
<td>o</td>
<td>o</td>
<td>o</td>
<td>o</td>
</tr>
</tbody>
</table>

### 28. Radiographically healed

- Yes
- No