

# 1-YEAR HIP FOLLOW-UP

It is important to review the status of your hip implant(s) during an office visit at six weeks, one year, two years, and every other year postoperatively thereafter for your safety even though you are feeling great. Long distance follow-up evaluations for out-of- state patients are fine. We would like to ask you to complete the following evaluation protocol.

- 1) *Hip questionnaire:* We keep track of each joint separately in our database. Therefore, I would like to request that you fill out a self rating form for **EACH** hip, even if both are identical. Please send to us.
- 2) *Physical Therapy:*
  - Add your name to the physical therapy evaluation request
  - Give the order and physical exam form to your physical therapist
  - Send the results to us
- 3) *Hip X-Ray:*
  - Add your name to the x-ray request
  - Have the x-ray of your hip(s) done at your local hospital or radiologist and request a CD copy of this x-ray be sent to us

As soon as we receive all of the above, I will review them and send you a written response. If you prefer to travel here for an office visit for evaluation, please call our appointment line to arrange this (803) 256-4107 (routine office charges will apply). If you are having significant problems with your hip, I will need to see you in the office for complete examination to best diagnose it.

Thank you for your attention to this matter. If you have any questions, please contact us for assistance.

Thomas P. Gross MD

Lee Webb, DNP, APRN, FNP-C

**Attached Forms:**

1. Follow up hip questionnaire (page 3-8)
- 2a. Physical exam form (page 9-10)
- 2b. Physical therapy evaluation letter (page 11)
- 2c. Physical therapy evaluation request (page 12)
3. Hip x-ray request (page 13)

- E-mail: [grosspatientfollowup@midlandsortho.com](mailto:grosspatientfollowup@midlandsortho.com)
- Call: (803) 933-6127
- FAX: (803) 933-6339

If you don't have any questions, please follow the protocol and fill out each form below, then FEDEX the packet to:

Dr. Thomas P. Gross  
Attn: Hip follow-up  
Midlands Orthopaedics & Neurosurgery  
1910 Blanding St.  
Columbia, SC 29201

# Hip Follow-Up Form

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Name: \_\_\_\_\_ Date \_\_\_\_\_

## Follow-up Information

**1. Where was this form completed?**

- Office
- Phone
- Mail-In
- Internet

**2. This questionnaire is for the evaluation of my (side) hip.**

- Left
- Right

**3. I have had problems with my (side) hip(s).**

- Left
- Right
- Both

**4. Dr. Gross has operated on my (side) hip(s).**

- Left
- Right
- Both

**5. Another surgeon has operated on my (side) hip(s).**

- Left
- Right
- Both

**6. Dr. Gross performed the followed operation(s) on me:**

- Total hip replacement
- Hip resurfacing
- Revision hip surgery
- Other: \_\_\_\_\_

## Complications

**1. List any complications you had post-surgery:**

- None
- Wound Infection
- Deep Venous Thrombosis
- Pulmonary Embolus (Blood clot travelling to lungs)
- Partial Sciatic Palsy (Nerve injury)
- Dislocation
- Fracture
- Loosened implant
- Other: \_\_\_\_\_

**2. Did you have any complications that required further surgery?**

- Yes; Please explain: \_\_\_\_\_
- No

## Clinical Function Score

**1. What category most closely represents your pain level?**

- None, or so insignificant that I ignore it
- Regularly slight
- Mild
- Moderate
- Severe
- Disabled

2. My hip pain is located in my (check all that apply):

- No pain
- Groin
- Front of thigh
- Buttock
- Side of thigh
- Side of hip, near scar
- Other pain: \_\_\_\_\_

3. Please circle your regular pain level on the following scale.



4. Please circle your highest hip pain level on the following scale.



5. Please indicate the severity of your limp, if any.

- None
- Slight
- Mild
- Moderate
- Severe
- Disabled

6. Please indicate your use of support, if any.

- None required
- Use of a cane or a stick for long walks or high activity only
- Use of a cane or a stick almost always
- Use of one crutch almost always
- Use of two crutches or a walker
- Unable to move across the room

**7. I am able to walk \_\_\_\_\_ without a break:**

- Over one mile/Unlimited
- 6 blocks or roughly 30 minutes
- 2-3 blocks or roughly 10-15 minutes
- Indoor walking only
- Bed and chair only

**8. Which of the following describes how you take stairs?**

- Normally foot-over-foot without NEEDING the railing
- Normally using the railing
- Leading with non-painful hip one step at a time
- Cannot take the stairs

**9. I am able to put socks/shoes on....**

- With ease
- With difficulty
- Unable to put socks or shoes on without help

**10. Under what circumstances can you sit comfortably?**

- Any chair/1+ hour
- High chair/30 minutes
- Unable to sit comfortably

**11. Are you able to get in and out of a vehicle without help?**

- Yes
- No

**12. Please list any unrelated orthopaedic issues that you believe might effect your hip function score (i.e. bad back, arthritis in other hip, non-hip pain, etc.)**

- Yes; please list: \_\_\_\_\_
- No

**13. How is your hip joint now compared to before surgery?**

- Better than my normal, healthy, pre-arthritis/damaged hip
- Feels just like my normal, healthy, pre-arthritis/damaged hip
- Much better than before surgery, with minor aches and pains
- Somewhat better than before surgery
- About the same
- Worse than before surgery

**Activity Score**

**1. Which best describes your current level of activity? (Please circle one.)**

Class	Description
1	Wholly inactive, dependent on others, and can not leave residence
2	Mostly inactive or restricted to minimum activities of daily living
3	Sometimes participates in mild activities, such as walking, limited housework, and limited shopping
4	Regularly participates in mild activities
5	Sometimes participates in moderate activities, such as swimming, or could do unlimited housework or shopping
6	Regularly participates in moderate activities
7	Regularly participates in active events, such as bicycling
8	Regularly participates in active events, such as bowling or golf
9	Sometimes participates in impact sports, such as jogging, tennis, skiing, acrobatics, ballet, heavy labor, or backpacking
10	Regularly participates in impact sports

**2. Please list any activities that you participate in regularly.**

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**3. Please list any vigorous activities that you occasionally participate in.**

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**4. My activity is now \_\_\_\_\_ compared to before surgery.**

- Higher
- Similar
- Lower

## Conclusions

5. Overall, are you happy with your decision to have this surgery?

- Yes
- No

6. Do you have any comments?

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Thomas P. Gross M.D  
 Midlands Orthopaedics  
 1910 Blanding St  
 Columbia SC 29201

<p><b>Office Use Only</b></p> <p>Date Received: ____/____/____</p> <p>Office Record Number: _____</p>
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**\*\*PATIENT TO FILL THIS SECTION\*\*:**

Name of patient being evaluated: \_\_\_\_\_  
 Date of Surgery: Right: \_\_\_\_\_ Left: \_\_\_\_\_  
 Type of Surgery: Right: \_\_\_\_\_ Left: \_\_\_\_\_  
 Interval from Surgery: \_\_\_\_\_

- |                   |                  |
|-------------------|------------------|
| <b>Right: N/A</b> | <b>Left: N/A</b> |
| <b>6 weeks</b>    | <b>6 weeks</b>   |
| <b>1 year</b>     | <b>1 year</b>    |
| <b>2 year</b>     | <b>2 year</b>    |
| <b>Or _____</b>   | <b>Or _____</b>  |

**TO BE COMPLETED BY A PHYSICAL THERAPIST**

- 1. Patient Charnley Category:**  
 A1: Unilateral with opposite hip normal  
 A2: Bilateral with satisfactory function of opposite hip  
 B: Unilateral other hip impaired \_\_  
 C: Multiple arthritis or medical infirmity

<b>2. Range of Motion:</b>	<b>Right</b>	<b>Left</b>
a. Flexion Contracture*	_____	_____
b. Flexion to**	_____	_____
c. abduction at 45 degees of flexion to	_____	_____
d. adduction at 45 degrees of flexion to	_____	_____
e. external rotation at 45 degrees of flexion to	_____	_____
f. internal rotation at 45 degrees of flexion to	_____	_____
g. IR with knee flexed to 90 degrees ***	_____	_____

\* Enter 0 if the leg is able to lie flat on the exam table.  
 \*\* Do not push past 100 degrees before 1 year  
 \*\*\*Do not perform this one until one year after surgery please

- 3. Gait:**
- Normal
  - Antalgic
  - Trendelenburg
  - Short Leg
  - Other \_\_\_\_\_

- 4. Trendelenburg Sign:**

- Positive
  - Negative
- 5. Active SLR painful?**
- No
  - Yes If Yes Where? \_\_\_\_\_
- 6. Strength SLR (grade 0-5):** \_\_\_\_\_
- 7. Strength Abduction (grade 0-5):** \_\_\_\_\_
- 8. Leg Length:**  
Equal    Left short \_\_\_\_\_    Right short \_\_\_\_\_
- 9. Tender:**
- No
  - Yes If yes, where? \_\_\_\_\_
- 10. Condition of incision:** \_\_\_\_\_

**Physical Therapist Signature:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please give a copy to the patient and mail one to me at the above address. Thank you.**

Updated 1/31/08

**MIDLANDS**  
**orthopaedics**  
**& NEUROSURGERY**

(803) 256-4107  
Fax: (803) 933-6339  
1910 Blanding St.  
Columbia, SC 29201  
1013 Lake Murray Blvd.  
Irmo, SC 29063

Dear Physical Therapist:

The person presenting this form has had a hip surface replacement performed by Dr. Thomas P. Gross \_\_\_\_\_ weeks/years ago. We are asking that you objectively evaluate his/her hip and send me a report. If the patient is less than one year postop, the hip cannot be pushed into extreme flexion, adduction and internal rotation. (See form). Please record the range of motion that can be achieved by gentle examination in this case.

If the patient is approximately six weeks postop, please review and assist them with my Phase II Hip Exercise Program. The patient has been instructed to bring this with him/her in this situation.

**Thomas P. Gross M.D**

**Please FAX to: 803-933-6339 and give the patient a copy.**

MIDLANDS  
**orthopaedics**  
& NEUROSURGERY

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FOR \_\_\_\_\_


R ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

Please evaluate both hips in the above patient for range of motion and strength and provide a report on my standardized form included.

**Thomas P. Gross M.D**

Please FAX to: 803-933-6339 and give the patient a copy.

Thomas P.  
Gross, MD

 Digitally signed by Thomas P.  
Gross, MD  
Date: 2019.05.29 08:40:02  
-04'00'

**MIDLANDS**  
**orthopaedics**  
**& NEUROSURGERY**

(803) 256-4107  
1910 Blanding St.  
Columbia, SC 29201  
1013 Lake Murray Blvd.  
Irmo, SC 29063

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R<sub>x</sub> FOR \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

Please select/circle ONE section (either 1, 2, or 3) to ensure the appropriate xrays are obtained from the patient's radiology facility.

1. LEFT
  - a. Diagnoses:
    - i. Osteoarthritis (OA) of the hip – **M16.12**
    - ii. Hip pain – **M25.552**
2. RIGHT
  - a. Diagnoses:
    - i. Osteoarthritis (OA) of the hip – **M16.11**
    - ii. Hip pain – **M25.551**
3. BILATERAL
  - a. Diagnoses:
    - i. Osteoarthritis (OA) of the hip – **M16.10**
    - ii. Hip pain – **M25.559**

Views (please include all of the following):

1. AP Pelvis Standing (Please label as "STANDING")
2. AP Pelvis Supine (Please label as "SUPINE")

Please provide the patient with a CD digital copy of these x-rays for my review, and mail to:

Midlands Orthopaedics & Neurosurgery

ATTN: Gross follow-up  
1910 Blanding Street  
Columbia, SC 29201

Thomas P.  
Gross, MD

Digitally signed by Thomas P.  
Gross, MD  
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