**MEDICAL EQUIPMENT AND HOME ENVIRONMENT QUESTIONNAIRE**

Please complete this form and bring it to the total joint replacement class you will attend before your surgery. This will help your health care team plan for your discharge from the hospital.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Surgery:</th>
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**Type of Surgery:**

1. Hip: [ ] Left  [ ] Right
2. Knee: [ ] Left  [ ] Right
3. Partial Knee: [ ] Left  [ ] Right
4. Revision/Redo Hip: [ ] Left  [ ] Right
5. Revision/Redo Knee: [ ] Left  [ ] Right

**Name of Person helping you after surgery:**

**Does anyone depend on you for care at home?**  [ ] Yes  [ ] No

**MEDICAL EQUIPMENT YOU CURRENTLY HAVE (PLEASE CHECK ALL THAT APPLY)**

- [ ] Rolling Walker (wheels on front only)
- [ ] Rollator (walker with 4 wheels & seat)
- [ ] Standard Walker (no wheels)
- [ ] Cane
- [ ] Quad Cane (4 legs)
- [ ] 3-in-1 Commode Chair
- [ ] Bedside Commode
- [ ] Built-in High Toilet
- [ ] Wheel Chair
- [ ] Reacher
- [ ] Sock Aid
- [ ] Other ___________________________________

**PLANNED DISCHARGE LOCATION**

- [ ] Outpatient Rehab
- [ ] Home Health
  
  Preferred Home Health Agency (please specify) ___________________________________

**FOR THERAPIST USE ONLY**

Right Knee Extension: __________________________  Right Knee Flexion: __________________________

Left Knee Extension: __________________________  Left Knee Flexion: __________________________

Community Ambulator: __________________________

Household Ambulator: __________________________

Special Notes: ____________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

**PLEASE RETURN THIS FORM TO THE TOTAL JOINT COORDINATOR AT THE END OF CLASS**