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PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

ORTHOPAEDICS CLINIC—INTERVENTION CHECKLIST

Date	Problem/ICD-9	Cast/Splint	Suture Removal	Wound Debridement	Signature	
Dressing Application		<input type="checkbox"/> Bacitracin <input type="checkbox"/> Ace	<input type="checkbox"/> Xeroform <input type="checkbox"/> Felt	<input type="checkbox"/> Adaptic <input type="checkbox"/> Others _____	<input type="checkbox"/> Gauze <input type="checkbox"/> Burnette	<input type="checkbox"/> Cling <input type="checkbox"/> Coban
Neurovascular Check: Pain related to casting: <input type="checkbox"/> Yes <input type="checkbox"/> No Color: <input type="checkbox"/> Normal <input type="checkbox"/> Blue <input type="checkbox"/> Pale <input type="checkbox"/> Capillary refill <3 seconds Sensation: <input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Able to move phalanges _____ notified of abnormal responses. Action taken: _____						
Barriers to Learning: <input type="checkbox"/> None <input type="checkbox"/> Language <input type="checkbox"/> Cognitive <input type="checkbox"/> Physical <input type="checkbox"/> Emotional/Poor Motivation Cast Care Instructions given to patient or _____ and reviewed. <input type="checkbox"/> Scheduled Visit <input type="checkbox"/> Unscheduled Visit ** Reason as stated by patient _____						
Response: <input type="checkbox"/> Verbalizes good understanding <input type="checkbox"/> Needs review <input type="checkbox"/> Taught other _____						

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