Anchor Clinical Assessment Form

DVM/VMD: _____ Facility/Clinic: _____

Doctor Email: _____ Clinic Ph#: _____

Patient ID/Name: _____ Surgery Date: _____

Age: _____ Breed: _____ Weight(lbs): _____ Gender: _____

Assessment Time Frame: ☐ 3-6 mo ☐ 7-12 mo ☐ >1yr Exact time point from surgery: _____

Anchor Type: ☐ Corkscrew ☐ FASTak ☐ SwiveLock Suture: ☐ #2 FW ☐ #5 FW ☐ FiberTape

Clinical Observations

Range of Motion: ☐ Normal ☐ Decrease flexion (_____ degrees) ☐ Decrease extension (_____ degrees)

Stability: ☐ 2-4mm ☐ 5-8mm ☐ >8mm

Body Condition Score: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

Emaciated **Ideal** **Obese**

Surgical Observations

Joint Exploration	☐ Arthroscopic	☐ Arthrotomy	(☐Medial/ ☐Lateral)	
CCL Status	☐< 25% tear	☐25-75% tear	☐>75% tear	
Debridement	☐None	☐Partial	☐Complete	
Meniscus	☐Intact	☐Partial Meniscectomy	☐ Release	☐Other _____

SUBJECTIVE CLINICAL OUTCOMES (check one)

☐ **Full Function -** restoration to, or maintenance of full intended level and duration of activities and performance from pre-injury or pre-disease status (without medication)

☐ **Acceptable Function -** restoration to, or maintenance of intended activities and performance from pre-injury or pre- disease status that is limited in level or duration and/or requires medication to achieve

☐ **Unacceptable Function** – all other outcomes

COMPLICATION(s) (check one and describe please)

☐ **Catastrophic** – complication or associated morbidity that causes permanent unacceptable function, is directly related to death, or is cause for euthanasia

☐ **Major** – complication or associated morbidity that requires further treatment based on current standards of care:

☐ Subsequent meniscal tear ☐ Instability/Failure ☐ Infection ☐ Other _____

☐ 1. Requires surgical treatment to resolve based on current standard of care

☐ 2. Requires medical treatment to resolve based on current standard of care

☐ **Minor** – not requiring additional surgical or medical treatment to resolve (e.g., bruising, seroma, minor incision problems, etc)

☐ **None**

_____

Sign and Date

Please fax all completed forms to Arthrex Vet Systems at ***(866) 898-2059****.*

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