To Whom It May Concern,

This client is considering attending an intensive Constraint-Induced Movement Therapy program within South Eastern Sydney Local Health District.

This program will be run at either Prince of Wales Hospital, St George Hospital or Sutherland Hospital by the Physiotherapy and Occupational Therapy teams.

This is a letter to request medical clearance for this client to attend a 2 week program. Due to the need to participate for four hours daily we request a medical review to avoid any foreseeable issues that may arise. It is the therapist's responsibility to ensure eligibility in terms of upper limb function.

Please find attached the following documents to be returned to us by yourself or the client:

1. **Client Details Form** (page 2): to be completed by the client
2. **Medical Clearance Form** (page 3-4): to be completed by the medical practitioner
3. **Medical Practitioner Information Sheet**

Kind Regards,

Occupational Therapists and Physiotherapists for CIMT

South Eastern Sydney Local Health District

Patient Details & Medical Clearance Form

PART ONE: *Patient to complete*

PATIENT INFORMATION

Name: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Email: _____

Gender: _____ Date of Birth: _____ Age: _____

Medicare Number: _____

Private Health Insurance: Yes/ No Provider: _____ Number: _____

CAREGIVER INFORMATION

Name: _____

Address: _____

Phone: _____ Email: _____

Relationship to patient: _____

Additional Contact Person: _____ Phone: _____

HEALTH PROFESSIONAL INFORMATION

Please list the names and contact details of any health professionals that you are seeing (or have seen within the last 6 months)

Occupational Therapist: _____

Physiotherapist: _____

Rehabilitation Specialist: _____

GP: _____

Patient Details & Medical Clearance Form

PART TWO: *Medical Practitioner to complete*

MEDICAL PRACTITIONER DETAILS

Name: _____

Position: _____ Organisation: _____

Phone: _____ Email: _____

Length of time treating this patient: _____

DIAGNOSIS

Date of stroke/ABI: _____ Type of Injury: _____

Side of body most affected: _____ Dominant Hand prior to event: _____

Past Medical History: _____

_____

_____

Current Medication and reason: _____

_____

_____

Does the patient take oral medication for spasticity? Yes No Name? _____

Has the patient received injections (such as botox) to decrease spasticity in their arm? Yes/No

If yes, when did they last receive injections? _____

To what muscles? _____

Highest grade of spasticity in upper limb (if known): _____

This patient has expressed interest in attending our 2 week constraint-induced movement therapy program. This involves attending a clinic for 4 hours a day for ten consecutive weekdays. During this program, they will complete 4 hours of upper limb therapy to the affected arm, and will be expected to wear a mitt on the unaffected arm for approximately 90% of each day during this 2 week period.

They will sign a behavioural contract and conditions will be negotiated for when they will be able to remove their mitt. This will occur for all activities affecting safety or hygiene if other safe solutions

cannot be found. For example, they may be able to use their affected arm to drink hot liquid from a travel mug with a lid, but not with a normal mug.

They may also participate in electrical stimulation (EMS) to their upper limb while on the program.

It is the responsibility of the treating clinicians to screen for eligibility regarding upper limb function and inclusions and exclusions based on our criteria. This request is to ensure that the client is medically cleared to participate in this intensive therapy program if they are deemed eligible.

Please sign the below declaration if you give this patient medical clearance to participate in the program. Please list any restrictions below:

_____
_____
_____
_____

Does this participant have any of the following which may preclude them from participating?

Uncontrolled seizures? Yes No

Dementia or severe cognitive impairment? Yes No

Other concerns? Yes No Details: _____

I agree that this patient _____ has been medically cleared to attend the Constraint-Induced Movement Therapy Program from _____ to _____ *(enter dates)*. Any restrictions have been listed above. I know of no reason why this patient would be unable to participate in the program.

Signature: _____ Date: _____

What is it? Constraint induced movement therapy (CIMT) is an evidence-based treatment method for people who have arm and hand use weakness following a stroke or other neurological impairment. It involves promoting use of the affected arm while restraining the unaffected arm with the purpose of: a) improving function, strength and movement of the affected arm and b) preventing or minimising learned non-use of the affected arm.

The Evidence: For stroke survivors with some active wrist and finger extension, intensive CIMT should be provided to improve arm and hand use (Clinical Guidelines for Stroke Management 2017, Stroke Foundation Australia). This is the ONLY upper limb treatment method listed with strong recommendation for provision within the guidelines.

The Program:

- 2 week intensive program, involving 4 hours supervised therapy per day, 1 hour of homework per day, and commitment to wear a constraint mitt on the unaffected hand 90% of the day for the duration of the program.
- Run once per year at each site: St George Hospital, Prince of Wales Hospital and Sutherland Hospital for a total of 3 programs per year.
- Open to all patients who live within SESLHD who meet the eligibility criteria.

Expectations:

Participants will be required to:

- Attend therapy for 4 hours a day for 10 consecutive working days. They will be required to use only their affected arm during that time.
- Wear a constraint mitt or sling on their non-affected arm for 90% of their waking hours throughout the full 2 weeks (this will be individually negotiated to ensure safety needs are being met).
- Complete homework and transfer package to encourage continuation of affected arm use once the two weeks have been completed.

Eligibility Criteria:

1. Stroke or ABI with unilateral upper limb weakness.
2. Brain tumour in remission with no active medical treatment.
3. 10 degrees active wrist and finger extension.
4. No significant pain, spasticity, or reduced range of motion – can be negotiated dependent on patient.
5. Ability to understand and follow instructions.
6. Motivation to participate in full program and ability to consent.
7. Independent with toileting.

For further information, please contact:

Via Email: SESLHD-Sutherland-CMTReferrals@health.nsw.gov.au

Via Telephone:

St George Hospital:

Jessica Worton

9113 2395

Prince of Wales Hospital:

Clare Griffin

9382 5190

Sutherland Hospital:

Elise Klumpes-Grant

9540 7475