Indian Fracture Registry

Registry Reference No: _____

Follow-up Assessment Form

Date of Assessment: ☐☐/☐☐/☐☐
DD MM YY

All fields are Mandatory unless otherwise indicated by *

PATIENT DETAILS			
Patient Name		**Date of Birth:** ☐☐/☐☐/☐☐ DD MM YY	
Mobile No:	☐☐☐☐☐☐☐☐☐☐	**Age (Years):** ☐☐	
City / Village		**Pin code:** ☐☐☐☐☐☐	
Gender	☐ Female ☐ Male ☐ Transgender		
Identity Type*	☐ Aadhar ☐ Driving License No. ☐ Voter ID ☐ Passport		
Identity Number*			

DOCTOR DETAILS			
Doctor Name			
Hospital Name			
WBOA Number:		**MCI Number:**	

FOLLOW UP ASSESSMENT					
Assessment After	☐ 1 month	☐ 3 months	☐ 6 months		
Fracture Status	☐ United	☐ Not United	☐ Uniting	☐ Delayed Union	
Range of movement (% of normal ROM)	☐ 0%	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Activities of the day (% of normal daily activity)	☐ 0%	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Adverse Incidents	☐ Infections	☐ Retrauma	☐ Weight Bearing Against Advice		
	☐ Poor Alignment	☐ Neuro-Vascular Damage			
Weight Bearing / Normal Activity Given	☐ Yes	☐ No			
Mortality	☐ Yes	☐ No			