Hi, and welcome to the world of regenerative orthopedic medicine. If you have found your way to this form you are interested in what regenerative orthopedic medicine can do to help with your specific musculoskeletal condition(s). You should fill out this form if you have been instructed to do so by a member of our care team, or if you have been referred to us by another doctor who thinks that regenerative orthopedic medicine can benefit you. The purpose of this form is to help determine if you would be a good candidate for the procedures we offer. IMPORTANT: in addition to this form you'll need to provide a copy of x-rays and (preferably) MRI of your affected joint(s) that is no less than 2 years old. This provides us with vital information that we need when determining your candidacy. We look forward to providing with the best regenerative orthopedic care that is currently available.

-Jonathan Fenton D.O.

-Evan Musman D.O.

Check list for phone evaluation:

- ❑ Contact a member of our care team at Vermont Regenerative Medicine 802-859-0000 or Vermont Pain Management 802-861-6100.
- ❑ Provide recent X-ray/MRI studies: please send a copy to **Vermont Regenerative Medicine Attn: Phone Evaluations, 321 Main St. Suite C, Winooski, Vermont 05404**
- ❑ Optional: Read Orthopedics 2.0 found here.

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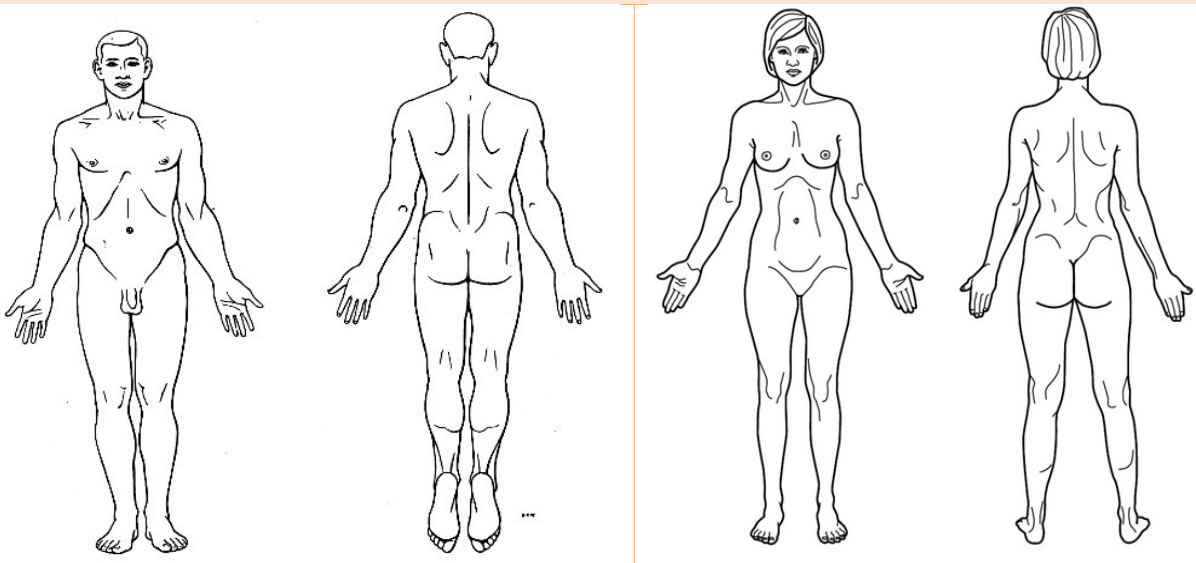
Phone Evaluation Information

Basic Personal Information

Name:		**Phone Number:**	
Email Address:		**Best time to call you:**	
Date of Birth:		**Sex:**	❑ Male ❑ Female
Height:		**Recent weight:**	
Referring Physician:			
Briefly describe how your problem(s) began:			
Current medications: ex. Aspirin 81mg 1x/daily			
Do you currently use/consume:	Tobacco or Tobacco products: ❑ No ❑ Yes Marijuana: ❑ No ❑ Yes, how often: Alcohol: ❑ No ❑ Yes, how many drinks per week:		
Treatments attempted:	❑ Nothing ❑ Ice or Heat ❑ Physical Therapy ❑ Steroid injections ❑ NSAIDs (Ibuprofen, Aleve, Naproxen), how often do you take them? Other treatments:		
List any past surgeries and the year performed:			

Location of Present Pain/Dysfunction

Please indicate where you suffer from pain or dysfunction and list from most to least severe**.** **Be specific!** ex. Inside of my right knee. Hint: use the highlighter function if filling out electronically



1:	
2:	
3:	
4:	
5:	

Functional Rating

In order to best evaluate your joint functionality please follow the link below and report the total score of your functional screening test.

For upper extremities (shoulders, elbows, wrists/hands) use [link]	For lower extremities (hips, knees, ankles/feet) use [**link**]	For spine (cervical, thoracic, lumbar/sacrum) use [link]
Total score:	**Total score:**	**Total score:**

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I hereby understand that I am freely volunteering this information to be used for my candidacy rating. I acknowledge that until I am physically seen by a physician and established as a patient any information I should receive about my conditions does not represent medical advice. I also understand that currently no regenerative medicine treatment is covered by any insurance and if I should elect to proceed with a regenerative medicine procedure that I will be required to pay the full price of the procedure on the day I undergo it.

Signature: _____ Date: _____