

ID sticker here

ATRS AS EQ-5D-5L

BOFAS Registry Version.

Prior to completing the Questionnaire please complete the following:-

Today's Date:

D	D	M	M	2	0				
				Y	Y	Y	Y		

On which side of your body is the affected joint, **for which you are receiving/have received treatment.**

Left ☐

Right ☐

Both ☐

To be completed by medical team:

Condition: _____

Pre-op ☐

Post-op ☐ _____ months _____ years

Entered on to registry ☐ Op on registry ☐

Height: _____

Weight: _____

BMI: _____

ASA: _____

Co-morbidities: _____

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Achilles Tendon Total Rupture Score (ATRS)

All questions refer to your limitations/difficulties related to your injured Achilles tendon.

Please make a mark in the appropriate box.

0 – impossible/major limitations	normal/no limitations – 10
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- 1 Are you limited because of decreased strength in the calf / Achilles tendon?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 2 Are you limited because of fatigue in the calf/Achilles tendon/foot?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 3 Are you limited due to stiffness in the calf/Achilles tendon/foot?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 4 Are you limited because of pain in the calf/Achilles tendon/foot?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 5 Are you limited during activities of daily living?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 6 Are you limited when walking on uneven surfaces?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 7 Are you limited when walking quickly upstairs or uphill?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 8 Are you limited during activities that include running?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 9 Are you limited during activities that include jumping?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- 10 Are you limited in performing hard physical labor?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

0 – impossible/major limitations	normal/no limitations – 10
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Achilles Tendon Rupture Repair Score (AS) (to be completed with the Physiotherapist)

Pain

None	15	<input type="checkbox"/>
Mild: no limited recreational activities	10	<input type="checkbox"/>
Moderate: limited recreational but not daily activities	5	<input type="checkbox"/>
Severe: limited recreational & daily activities	0	<input type="checkbox"/>

Stiffness

None	15	<input type="checkbox"/>
Mild: occasional, no limited recreational activities	10	<input type="checkbox"/>
Moderate: limited recreational but not daily activities	5	<input type="checkbox"/>
Severe: limited recreational & daily activities	0	<input type="checkbox"/>

Calf muscle weakness (subjective)

None	15	<input type="checkbox"/>
Mild: no limited recreational activities	10	<input type="checkbox"/>
Moderate: limited recreational but not daily activities	5	<input type="checkbox"/>
Severe: limited recreational & daily activities	0	<input type="checkbox"/>

Footwear restrictions

None	10	<input type="checkbox"/>
Mild: most footwear tolerated	5	<input type="checkbox"/>
Moderate: unable to tolerate fashionable shoes, modified shoes tolerated	0	<input type="checkbox"/>

Active Range of Motion difference between ankles

Normal: $\leq 5^\circ$	15	<input type="checkbox"/>
Mild limited: $6^\circ - 10^\circ$	10	<input type="checkbox"/>
Moderately limited: $11^\circ - 16^\circ$	5	<input type="checkbox"/>
Severely limited: $> 16^\circ$	0	<input type="checkbox"/>

Subjective result

Very satisfied	15	<input type="checkbox"/>
Satisfied with minor reservations	10	<input type="checkbox"/>
Satisfied with major reservations	5	<input type="checkbox"/>
Dissatisfied	0	<input type="checkbox"/>

Isokinetic muscle strength

Excellent: single leg heel raise to same height as other leg. No hand support	15	<input type="checkbox"/>
Good: single leg heel raise not to the same height as other leg, min hand support required.	10	<input type="checkbox"/>
Fair: just about single leg heel raise, max hand support required	5	<input type="checkbox"/>
Poor: unable to single leg heel raise	0	<input type="checkbox"/>

EQ-5D-5L

Under each heading, please tick ONE box that best describes your health TODAY.

Mobility:

- I have no problems in walking about ☐
- I have slight problems in walking about ☐
- I have moderate problems in walking about ☐
- I have severe problems in walking about ☐
- I am unable to walk about ☐

Self care:

- I have no problems washing or dressing myself ☐
- I have slight problems washing or dressing myself ☐
- I have moderate problems washing or dressing myself ☐
- I have severe problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

Usual activities: (eg work, study, housework, family or leisure activities)

- I have no problems doing my usual activities ☐
- I have slight problems doing my usual activities ☐
- I have moderate problems doing my usual activities ☐
- I have severe problems doing my usual activities ☐
- I am unable to do my usual activities ☐

Pain / Discomfort:

- I have no pain or discomfort ☐
- I have slight pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have severe pain or discomfort ☐
- I have extreme pain or discomfort ☐

Anxiety / Depression:

- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

Continued overleaf...

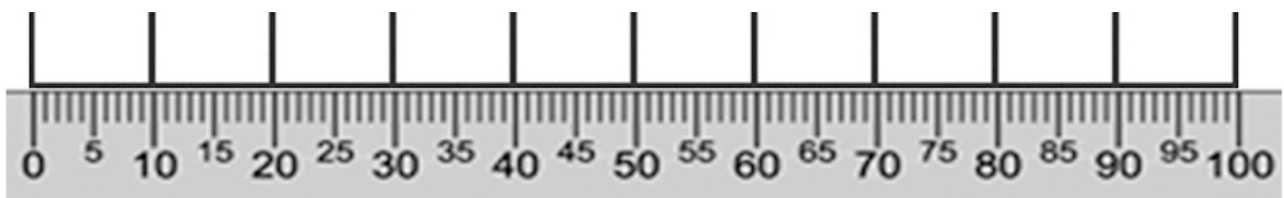
EQ-5D-5L

We would like to know how good or bad your health is TODAY.

- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
- 0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.

Worst

Best



Thank you for completing this form.