Mount Sinai

Abilities Research Center

Department of Rehabilitation and Human Performance
5 E 98th St., SB-18, New York, NY 10029

ARC Clinical Program

Contact Information *Please provide us with the following contact information.*

First & Last Name		Street Address (Apartment #)	
DOB			
Telephone		City, State and ZIP Code	
Email Address		Are you A US Veteran	
Emergency Contact		Phone	
		Handedness (Dominant Hand)	

Disease Related Information *Please check off or fill in the following (as applicable).*

Stroke			
Date of injury		Stroke type	Ischemic (blood clot) ☐ Hemorrhagic ☐
Lesion Location	Cortical ☐ Subcortical ☐ Mixed ☐	Stroke Location	Left ☐ Right☐
Body Weakness	Left ☐ Right ☐	Weak Limbs	Left ☐ Right ☐
Spinal Cord Injury			
Date of injury		Lesion Type	Complete ☐ Incomplete ☐
Injury Level		ASIA Type	
Others			

Preferred Appointment	**Dates** *(Mon-Fri)*	**Times** *9-7pm*
Option 1		9am-11am ☐12pm-2pm☐ 3pm-5pm ☐ 6pm-7pm☐
Option 2		9am-11am☐ 12pm-2pm☐ 3pm-5pm ☐ 6pm-7pm ☐
Option 3		9am-11am ☐12pm-2pm☐ 3pm-5pm ☐ 6pm-7pm☐

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ARC Clinical Programs

PROGRAMS

Please select which of the program(s) you are interested by marking ☒ in the left column. A summary is provided under each program. The program frequency will be modified according to patients' individual needs.

	Program	Prices
☐	**Hocoma Armeo Spring (Arm/Hand)**	1hour session @200per session
☐	**Exoskeleton (locomotion training)**	1hour session @300per session
☐	**Transcranial Magnetic Stimulation (TMS)**	30min session @200per session

Description

Hocoma Armeo Spring (Arm/ Hand) This device enables patients to use any remaining motor functions and encourages them to achieve a higher number of reach and grasp movements based on specific therapy goals. This repetitive training is based on the patient's own movements, which leads to better, faster results, and improved long-term outcomes.

Exoskeletons are assistive robotic devices for walking. Designed to help patients stand and walk sooner than during traditional rehabilitation; exoskeletons promote correct movement patterns in all phases of recovery, and challenges patients as they progress toward independent ambulation. Clinical evidence shows that incorporating exoskeletons in rehabilitation improves functional balance, walking distance, and gait speed in certain patient populations.

TMS is applied through a magnetic coil that induces a transient high-intensity magnetic pulse that penetrates through the scalp, skull and meninges and causes neurons to depolarize and generate action potentials. The participant will feel a muscle twitch when applying TMS.

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Review & Physician Approval Form

EXERCISE READINESS QUESTIONNAIRE *Please mark all that apply.*

☐ Are you over age 65 and not accustomed to vigorous exercise?
☐ Do you have frequent pains in your heart and chest?
☐ Do you often feel faint or have spells of severe dizziness?
☐ Has your doctor ever told you your blood pressure was too high?
☐ Has your doctor ever told you have a bone or joint problem such as arthritis that has been aggravated by exercise?
☐ Has your doctor ever said you have heart trouble?
☐ Is there a good physical reason why you should not exercise even if you wanted to?

COMORBID DISEASES/MEDICAL CONDITIONS *Please mark all that apply.*

PULMONARY	☐ Allergies	☐ Asthma	☐ Bronchitis	☐ Pulmonary Edema	☐ Emphysema	
MUSCULOSKELETAL	☐ Fibromyalgia	☐ Limited Motion in Joints	☐ Osteoarthritis	☐ Osteoporosis	☐ Rheumatoid Arthritis	
CARDIOVASCULAR	☐ Heart Attack	☐ High Blood Pressure	☐ High Cholesterol	☐ Low Blood Pressure	☐ Stroke	☐ Pacemaker or Defibrillator
OTHER	☐ Anemia	☐ Depression	☐ Diabetes	☐ Epilepsy or Seizures	☐ Hearing Impairment	
	☐ Parkinson's	☐ Pregnant	☐ Post-Natal	☐ Alzheimer's	☐ Psychiatric Disorder	

NON-INVASIVE BRAIN STIMUATION QUESTIONNAIRE *Please mark all that apply **only** if you are interested in the TMS program.*

☐ Have you ever had a seizure?
☐ Do you have migraines?
☐ Do you have any metal in your head such as shrapnel, surgical clips or fragments from welding?
☐ Do you have any implanted medical devices such as a pacemaker or medical pump?

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Risk Review & Physician Approval Form

PHARMACOLOGICAL TREATMENT/MEDICATION *(please provide a list)*

PHYSICIAN CLEARANCE AND RECOMMENDATIONS

Physician name: Phone:

Specialty:

I approve of my patient's participation in the Abilities Research Center Clinical Program, with the following guidelines or recommendations:

Physician: Signature

Date:

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Liability Waiver

I _____ wish to enroll in the Abilities Research Center (ARC) Clinical Program at the Rehabilitation and Human Performance Department at Mount Sinai. I understand that exercising in this program may involve a variety of physical activities including, but not limited to stretching, Range of Motion and strengthening with motorized robotic devices. I understand that participation in this program is voluntary and not medically prescribed therapy. I hereby affirm that I do not now suffer, nor have I ever suffered, from any medical condition, impairment or disability that would prevent or limit in any way my participation in this program.

I fully understand and assume risk that I may suffer injury as a result of my participation in the Abilities Research Center. These risks include, but are not limited to, changes in blood pressure or heart rate, dizziness, falls, muscle strain or pulls, soreness and in rare cases serious illness such as heart attack. There is some risk of injury to bones, joints, and/or muscles. I am willing to assume such risk. My physician approves of my participation in this program.

In consideration of my participation in the Abilities Research Center Clinical Program, I for myself, my heirs, executors, administrators, representatives and assigns hereby discharge The Abilities Research Center, its employees, subsidiaries, affiliates, offices, directors, agents, successors, assigns, and/or representatives, from any and all claims, demands, causes of action, suits, charges, liabilities, and expenses (including attorney's fees) of any nature whatsoever, now or in the future, arising from my participation in the Abilities Research Center Clinical Program including but not limited to liability related to the injuries listed above, however caused, whether they occur during or after my participation in these programs.

I hereby affirm that I have read and fully understand the above, and that my signing of this waiver is knowing and voluntary.

I hereby give the Abilities Research Center permission to access my medical record and contact me via phone, email or mail to alert me if I appear eligible for a therapeutic program.

Print Name _____ Date _____

Signature _____