Lower Limb Prosthetic Rehabilitation in Canada: A Survey Study

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ABSTRACT

Purpose: This study describes prosthetic rehabilitation services provided to individuals who have had a lower limb amputation in Canada. **Method:** This cross-sectional survey study used an online survey to collect data from facilities that provide lower limb prosthetic rehabilitation; it included questions about approaches and types of service, therapies, focus of service, and health care providers. One representative from each facility was asked to complete the survey. **Results:** Of the 65 identified eligible facilities, 59 completed the survey (response rate = 90.8%). The majority of facilities ($n = 39$; 66.1%) indicated that they provided both in-patient and outpatient prosthetic rehabilitation services. All facilities provided balance, coordination, and gait training as well as prosthetic fit education. Most facilities indicated that they had a physical therapist ($n = 58$; 93.8%), an occupational therapist ($n = 52$; 88.1%), and a prosthetist ($n = 52$; 88.1%) on their team. **Conclusions:** The majority of the facilities surveyed provided both in-patient and outpatient services and had specialized health care provider teams. Future surveys are required to collect more specific information about prosthetic rehabilitation in Canada.

Key Words: amputation; prostheses; rehabilitation; survey.

RÉSUMÉ

Objectif : décrire les services de réadaptation avec prothèse du Canada pour les personnes amputées des membres inférieurs. **Méthodologie :** une étude transversale en ligne a permis d'amasser des données auprès d'établissements qui offrent une réadaptation avec prothèse des membres inférieurs. Elle incluait des questions sur les approches et les types de services, les traitements, l'objet des services et les professionnels de la santé. Un représentant de chaque établissement était invité à remplir le sondage. **Résultats :** des 65 établissements admissibles répertoriés, 59 ont rempli le sondage (taux de réponse = 90,8 %). La majorité des établissements ($n = 39$, 66,1 %) a indiqué qu'il offrait des services de réadaptation avec prothèse aux patients hospitalisés et ambulatoires. Tous les établissements offraient un entraînement sur l'équilibre, la coordination et la démarche et de l'information sur l'ajustement des prothèses. La plupart des établissements indiquaient qu'ils comptaient un physiothérapeute ($n = 58$, 93,8 %), un ergothérapeute ($n = 52$, 88,1 %) et un prothésiste ($n = 52$, 88,1 %) au sein de leur équipe. **Conclusions :** la majorité des établissements sondés offraient à la fois des services aux patients hospitalisés et ambulatoires et étaient dotés d'équipes soignantes spécialisées. Il faudra réaliser d'autres sondages pour colliger de l'information plus précise sur la réadaptation avec prothèse au Canada.

Lower limb amputation (LLA) is a disabling condition that negatively affects individuals' mobility and quality of life.¹⁻² Prosthetic rehabilitation, defined as fitting a prosthesis on a patient and training the person to use it and walk with it, is critical for helping individuals with LLA achieve the level of mobility required to participate in daily and social activities.³⁻⁴ Prosthesis use is important because it has been linked to improved perceived quality of life and increased level of function and independence in this population.⁵⁻⁶

Prosthetic rehabilitation is usually a multi-step process: it begins by assessing individuals' needs, goals, and expectations; fabricating and fitting a prosthesis; ambulation and gait training; and follow-up visits to improve

and maintain prosthetic fit and prosthetic use.⁷ Informal reports have suggested that, in Canada, there are different models of care for lower limb prosthetic rehabilitation, with different lengths of in-patient or outpatient rehabilitation.⁸ Some rehabilitation facilities provide highly structured prosthetic rehabilitation with a multidisciplinary team of professionals, and others provide rehabilitation on an ad hoc basis with a limited number of clinicians.

Currently, evidence-based understanding about the current practices and service delivery models used in lower limb prosthetic rehabilitation in Canada is lacking. We speculate that considerable variability exists in Canada, where, despite its universal health care system, there

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are tremendous differences in how health care is delivered. A better understanding of existing lower limb prosthetic rehabilitation practices and service delivery models is important to inform policy-makers and managers about rehabilitation services so that they can promote best practices. Therefore, the objective of this study was to describe the prosthetic rehabilitation services provided to individuals with LLA in rehabilitation facilities across Canada. To that end, we investigated the approaches these facilities used for prosthetic rehabilitation, including models of care and types of therapy used. We also looked at the demographics of the clients who received the rehabilitation.

METHODS

Design and sample

We used a cross-sectional, online survey designed to collect information from Canadian public facilities that provide lower limb prosthetic rehabilitation. The three Canadian territories were not included because they do not have rehabilitation facilities.

We identified these facilities using the following sources:

1. The 2011 version of the *Guide to Canadian Healthcare Facilities*, which we used to identify public facilities that provide rehabilitation.⁹ We identified these facilities by searching on the following terms: *acute care hospitals*, *long-term care facilities*, and *outpatient health services centres*, coupled with at least one of the following keywords, which suggested *rehabilitation centre or service*: *rehab*, *rehab ctr*, *reg rehab ctr*, or *rehab serv*.
2. The latest list (fiscal year 2013–2014) of the facilities that had submitted rehabilitation data on LLAs, which we obtained from the National Rehabilitation Reporting System.

We used both sources to maximize the number of prosthetic facilities we could identify. So that we did not miss any Quebec facilities listed in the *Guide to Canadian Healthcare Facilities*, we enlisted the help of a bilingual researcher with extensive knowledge of those rehabilitation facilities, who identified them.

We contacted all facilities identified to find out whether they met the study inclusion criteria. Facilities were included if they provided lower limb prosthetic rehabilitation, had a minimum of 10 rehabilitation beds designated for any diagnosis, and had at least five clients with LLA who received prosthetic rehabilitation per year.

Research assistants telephoned the rehabilitation department of each facility and spoke to the clinical practice leaders. The research assistants provided general details about the survey and determined the facility's eligibility. If a facility was ineligible, it was removed from

the list; if it was eligible, the practice leaders were asked whether they were willing to participate in the survey on behalf of the facility. If the answer was yes, the email address of one representative from each facility was obtained to complete the survey.

We contacted the representatives by email. The message included an introductory study letter, details of the study, and a link to the survey. Dillman's tailored design method was used to increase the response rate and build trust.¹⁰ If participants opened the survey link, they were directed to the consent form, which included the option "I agree" to indicate consent. After providing consent, participants were directed to the survey. Reminder emails were sent to all participants at 2, 4, and 6 weeks after initial email contact, regardless of completion status, because the survey responses were anonymous.¹⁰

Survey development

We developed the survey in English on the basis of the existing literature, the areas of interest, and clinical experience and refined it through five iterations. The first iteration was reviewed by three Canadian clinical researchers: an occupational therapist–epidemiologist (WCM), a physiatrist (HCF), and a physical therapist. The second iteration was reviewed by 10 Canadian researchers with various backgrounds in physical and occupational therapy. The third iteration was piloted with two therapists (a physical and an occupational therapist) who provide lower limb prosthetic rehabilitation in Canada.

The lead author (BI) then met with the two therapists to refine the items using the think-aloud approach. This approach asks participants to think out loud as they respond to the survey questions, thereby helping to provide insight into whether the items were being construed as intended.¹¹ The technique has been shown to be useful in identifying problematic items in health-related survey design and outcome measure development.^{12–13} On the basis of the findings from this process, we refined the survey items and their response categories. The fourth iteration of the survey was edited for clarity and grammar by three research assistants, and the final iteration was reviewed and approved by the authors.

The final English version of the survey was translated into French by a bilingual research assistant, and the French version was back-translated into English by another translator. The bilingual research assistant and BI reviewed the back-translations, and discrepancies were reviewed and corrected.

The final survey (see [Appendix](#)) consisted of 15 closed-ended questions about the details of the facilities' lower limb prosthetic rehabilitation. The questions addressed provision of in-patient and outpatient prosthetic rehabilitation; whether a facility provided a dedicated prosthetic rehabilitation programme (i.e., programmes that only enrolled amputees); annual number of enrolled in-

Figure 1 Number of participating facilities in each province.

patient and outpatient clients with LLA; number of in-patient and outpatient clinicians providing lower limb prosthetic rehabilitation; types of prosthetic rehabilitation therapies (e.g., balance training) provided; length of prosthetic rehabilitation by level of LLA; annual number of clients fitted with a prosthetic limb; age range of clients; and types of health care provider (e.g., physical therapists) who were part of the prosthetic rehabilitation team.

The study was approved by the Clinical Research Ethics Board of the University of British Columbia.

Data management and statistical analyses

The survey was generated and managed using Fluid-Surveys (Fluidware Corporation, Ottawa, ON), which saves and stores data on a Canadian server. The data were then exported into Microsoft Excel 2007 (Microsoft Corporation, Redmond, WA) for decoding, organizing, and analyzing. We used summary statistics (mean, standard deviation, frequency, and percentage) and graphs (histogram and stacked column) to describe the sample and address the study objectives.

RESULTS

Demographic and descriptive data

In total, 159 public rehabilitation facilities were identified and contacted for eligibility. Of those, 65 met the eligibility criteria. The survey link was sent to a representative from each of the 65 facilities.

Of those 65 representatives, 59 completed the survey (response rate = 90.8%). All Canadian provinces were represented in the study (Figure 1). Ontario and Quebec had the greatest representation ($n_s = 25$ and 13; 42.4% and 22.0%, respectively), and Manitoba, Nova Scotia, and

Newfoundland and Labrador had the lowest representation ($n = 1$; 1.7% each).

Prosthetic rehabilitation data

Approaches and types of service

The majority of the facilities ($n = 39$; 66.1%) indicated that they provided both in-patient and outpatient lower limb prosthetic rehabilitation services, whereas others indicated that they provided only in-patient ($n = 10$; 16.9%) or only outpatient ($n = 10$; 16.9%) lower limb prosthetic rehabilitation services.

Of the facilities that provided in-patient prosthetic rehabilitation, 27 (55.1%) admitted clients under their general in-patient rehabilitation programme, 10 (20.4%) admitted clients under a specific in-patient rehabilitation programme (e.g., musculoskeletal), and 12 (24.5%) admitted clients to a dedicated amputee prosthetic rehabilitation programme.

Of the facilities that provided outpatient prosthetic rehabilitation, 18 (36.7%) serviced clients through a dedicated amputee prosthetic rehabilitation programme, 17 (34.7%) serviced clients through a specific outpatient rehabilitation programme (e.g., musculoskeletal), and 14 (28.6%) serviced clients through their general outpatient rehabilitation programme.

Twenty-two (45.0%) of these facilities provided 4–6 weeks of in-patient prosthetic rehabilitation for individuals with unilateral transtibial amputation, and 59.2% ($n = 29$) provided 4–6 weeks of in-patient prosthetic rehabilitation for individuals with unilateral transfemoral amputation. For individuals with bilateral transtibial amputation, 20 (40.8%) facilities provided 4–6 weeks of in-patient prosthetic rehabilitation, and 10 (20.4%) provided 10–12 weeks of in-patient prosthetic rehabilitation.

Figure 2 Length of (a) in-patient prosthetic rehabilitation ($n = 49$) and (b) outpatient prosthetic rehabilitation ($n = 49$) by level of LLA.

Last, for individuals with bilateral transfemoral amputation, most facilities provided 10 or more weeks of in-patient prosthetic rehabilitation ($n = 30$; 61.2%). (These data are shown in [Figure 2a](#).)

Of facilities that provided outpatient rehabilitation, 16 (32.7%) provided 4–6 weeks of outpatient prosthetic rehabilitation to clients with unilateral transtibial amputation; 16 (32.7%) provided more than 12 weeks of rehabilitation to clients with unilateral transfemoral

amputation. Seventeen (34.7%) provided more than 12 weeks of outpatient prosthetic rehabilitation for individuals with bilateral transtibial amputation, as did 29 (59.2%) for individuals with bilateral transfemoral amputation. (See [Figure 2b](#).)

Types of therapy

All 59 facilities provided balance and coordination training, gait training, and prosthetic fit education. Fifty-

Figure 3 Types of therapy provided in lower limb prosthetic rehabilitation programmes ($n = 59$).

seven (96.6%) provided flexibility and range of motion (e.g., muscle stretching), 55 (93.2%) provided cardiovascular training (e.g., aerobic fitness training), and 51 (86.4%) provided muscle strengthening. Of these facilities, 25 (42.4%) indicated that they provided support groups, and 12 (20.3%) provided other therapies, such as aquatic therapy, a school integration programme, nutritional education, stress management, phantom pain and body image education, home interventions and home visits, and gaming rehabilitation (Figure 3).

Focus of service

The majority of the 59 facilities ($n = 57$; 96.6%) provided prosthetic rehabilitation services to clients aged 50–64 years (Figure 4). Respondents were asked to select all ages that they served.

Each year, a mean of 30 (SD 30.5) clients with LLA were admitted as in-patients, and 23 (SD 19.4) were serviced as outpatients. Of those admitted as in-patients, 23 (76.7%) were fitted with a prosthesis; of those serviced as outpatients, 21 (91.3%) were fitted with a prosthesis.

Health care providers

An average of 4.5 (SD 3.1) health care providers (full time or part time) provided in-patient lower limb pros-

thetic rehabilitation, and an average of 3.3 (SD 3.1) health care providers (full time or part time) provided outpatient lower limb prosthetic rehabilitation.

The majority of the 59 facilities indicated that their team consisted of a physical therapist ($n = 58$; 98.3%), an occupational therapist ($n = 52$; 88.1%), and a prosthetist ($n = 52$; 88.1%). Another 47 (79.7%) facilities reported that their team had a social worker, 45 (76.3%) had a nurse, and 43 (72.9%) had a physiatrist. (This breakdown is shown in Figure 5.) Finally, 21 (35.6%) facilities specified having other health care professionals as part of their team, including a hospitalist, educator specialist, rehabilitation assistant, kinesiologist, care coordinator, speech therapist, and sexologist.

DISCUSSION

National clinical survey studies provide insight into the current practices in and provision of health care services across the country, thereby illuminating geographical and professional variation in clinical practice. Having a better understanding of this situation enables health care providers and policy-makers to promote best practices as well as manage and allocate rehabilitation services.

Figure 4 Percentage of facilities providing lower limb prosthetic rehabilitation services, by age group ($n = 59$).

Figure 5 Types of health care providers composing prosthetic rehabilitation teams ($n = 59$).

In this study, Canadian public facilities that provide lower limb prosthetic rehabilitation were surveyed. The response rate of 91% was excellent. The results indicated that most facilities provided both in-patient and outpatient prosthetic rehabilitation. Those providing in-patient rehabilitation admitted most clients to their general in-patient programme, and those providing outpatient rehabilitation serviced most clients in dedicated amputee outpatient programmes. In terms of the length of prosthetic rehabilitation (whether in-patient or outpatient), the majority of facilities provided 4–6 weeks to clients with unilateral transtibial amputation. Whereas in-patient rehabilitation was mostly 4–6 weeks for clients with unilateral transfemoral amputation, outpatient rehabilitation was longer (usually >12 wk) for these clients. Similarly, for clients with bilateral transtibial amputation, most facilities provided 4–6 weeks of in-patient prosthetic

rehabilitation and more than 12 weeks of outpatient rehabilitation. Most clients with bilateral transfemoral amputation received 10–12 weeks or more than 12 weeks of in-patient rehabilitation, whereas outpatient rehabilitation was mostly more than 12 weeks. Our findings were similar to US data, which show that the length of prosthetic rehabilitation for clients with transtibial amputation is the shortest—approximately 4–6 weeks;¹⁴ for clients with transfemoral amputation, rehabilitation is longer (6–12 weeks); and for clients with bilateral transfemoral amputation, it is usually 12 weeks or more.¹⁴

Generally, clients with a higher level of bilateral amputation require longer periods of prosthetic rehabilitation because higher levels of amputation are associated with a greater degree of loss of function.¹⁴ In addition, the amount of energy that clients expend in prosthetic walking increases significantly for higher level and bilateral

amputations because of the weight of the prosthesis.¹⁵ Compared with able-bodied individuals, clients with unilateral transtibial amputation expend 40%–60% more energy, clients with unilateral transfemoral amputation expend 90%–120% more, clients with bilateral transtibial amputation expend 60%–100% more, and clients with bilateral transfemoral amputation expend more than 200% more.^{16–17} This notable increase in energy expenditure highlights the importance of prosthetic rehabilitation in helping clients build the fitness level required for prosthetic walking.¹⁵

Our results showed that a high percentage of clients (77%) admitted to in-patient rehabilitation, and an even higher proportion (90.6%) admitted to outpatient rehabilitation, are fitted with a prosthesis in Canadian prosthetic facilities. Other studies across the world have reported varied rates of prosthetic fitting, with a range as wide as 30%–92%.^{4,18} One of the reasons for this variation has been related to the patient population studied.⁴ Studies with the lower rates of prosthesis fitting have focused on older patient populations with vascular-origin and higher level amputations who are known to have a substantially lower rate of prosthetic fitting and usage.^{4,19–20} Other reasons for such variation have been attributed to different definitions of prosthetic fitting and the time at which prosthetic fitting was evaluated.⁴ For example, Webster and colleagues⁴ showed that prosthetic fitting at 4 months after amputation was 53%, whereas at 12 months, it was 92%. In our study, we asked for a general rate of prosthesis fitting for all clients (all age ranges and aetiologies) without specifying a time point.

It is worth mentioning that although it appears that a high percentage of clients who are admitted to rehabilitation in Canada are fitted with a prosthesis, this result represents only those who are actually admitted. Depending on the regional practice and availability of resources, many clients with LLA may never be admitted to rehabilitation as a result of advanced age or illness; therefore, they are not going to use a prosthesis, and their rehabilitation needs may be met through other approaches, such as home care services.

Our study showed that the majority of Canadian prosthetic facilities surveyed reported providing a rehabilitation programme that included balance and coordination, range of motion, and gait training; cardiovascular training; strengthening; and prosthetic fit education. A full 100% of the facilities reported that their lower limb prosthetic rehabilitation programme included balance and coordination training as well as gait training. Balance and gait training are crucial because they are two aspects of physical function that most deteriorate post-amputation and are most essential for restoring walking ability, which is the main goal of prosthetic rehabilitation.²¹

Flexibility, range of motion, and cardiovascular training were also reported to be part of prosthetic rehabilita-

tion programmes at more than 90% of the facilities in this study. Flexibility and range-of-motion exercises are critical for preparing the residual limb for prolonged periods of prosthetic use and reducing the chance of developing contractures, which are common in this population.²² Cardiovascular training is another important component of prosthetic rehabilitation because it helps improve clients' aerobic fitness and enables them to meet the increased energy demand of walking with a prosthesis.^{15–17}

In terms of the health care providers who made up the prosthetic rehabilitation team, the majority of facilities reported having a specialized team of health care professionals. Almost 100% reported that they had a physical therapist on their patient care team. About 90% reported that they had an occupational therapist and a prosthetist, and 73%–80% reported having a physiatrist, a social worker, and a nurse as part of their team. This is encouraging because outcomes have been reported to be optimized when patients interact with a multidisciplinary health care team.²³

This study only begins to describe prosthetic rehabilitation in Canada. More research is required to obtain a full picture of these services.

This study had several limitations. First, despite putting considerable effort into identifying all public prosthetic facilities in Canada, we missed smaller and private amputee clinics. Next, although we sent the survey link to only one representative at each facility, the anonymity of the survey limited our ability to ensure that all facilities had only one respondent. Also, because of this anonymity, we do not know whether the respondents completing the survey actually looked up specific data on their facility's length of stay, clients' age, and so forth or merely estimated their responses on the basis of their experience.

Another limitation of this study is that the survey focused on initial fitting and gait training. As a result, it did not capture the entire spectrum of clients' prosthetic training, such as clients who transitioned from in-patient to outpatient or clients who had received previous initial gait training as in-patients but were returning to an outpatient programme to learn new skills or improve their functional skills. Our survey also represented only clients who had been admitted to rehabilitation; hence, our data, such as the percentage of prosthetic fitting, cannot be generalized to the entire amputee population. In addition, the wording of some of the questions may have been confusing or misleading and may have affected the responses even though we endeavoured to minimize this issue by piloting the survey and refining it through multiple iterations before data collection.

There were other limitations as well. For example, because of the small sample size and the unequal representation of prosthetic facilities in Canadian provinces, the survey did not examine provincial differences; future studies should aim to look at provincial and urban–rural

differences. The survey also looked at variability in the length of rehabilitation only by level of amputation, not by client age. In addition, because we aimed to keep the survey short to increase the completion rate, we were limited in the number of questions we could ask and their level of specificity. Future surveys should include more specific questions about prosthetic rehabilitation. Finally, reporting or recall bias might be another limitation.²⁴ As with any self-report data, there is a possibility that the participants reported false or inaccurate information;^{24–25} future studies should use a more robust methodology, such as hospital chart reviews.

CONCLUSIONS

This was the first Canadian survey to investigate current practices in and service provision of lower limb prosthetic rehabilitation. The majority of prosthetic rehabilitation facilities reported that they provided both in-patient and outpatient services and had specialized health care provider teams consisting of a physical therapist, an occupational therapist, a prosthetist, a social worker, a nurse, and a physiatrist.

This study has clinical relevance for facilities and health care professionals involved in providing prosthetic rehabilitation to individuals with LLA. Knowledge of prosthetic rehabilitation services could also be helpful to policy-makers and managers of rehabilitation services.

KEY MESSAGES

What is already known on this topic

There is a dearth of evidence-based data on lower limb prosthetic rehabilitation in Canada. Informal reports have suggested that there are different models of care for lower limb prosthetic rehabilitation with different lengths of in-patient and outpatient rehabilitation.

What this study adds

The majority of the lower limb prosthetic rehabilitation facilities in Canada provide both in-patient and outpatient services and have specialized health care provider teams consisting of a physical therapist, an occupational therapist, a prosthetist, a social worker, a nurse, and a physiatrist. All facilities provide balance and coordination training, gait training, and prosthetic fit education; however, only one-third of the facilities provide return-to-work or recreational therapy.

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APPENDIX: NATIONAL LOWER LIMB PROSTHETIC SURVEY

Lower Limb Prosthetic Rehabilitation Services Provided in Your Facility

For this survey, we have defined *prosthetic rehabilitation* as training someone to use a prosthesis.

- Does your facility provide **in-patient** rehabilitation services to clients with lower limb amputation?

• ☐ Yes ☐ No If no → Skip questions 2–6

- Does your facility have a dedicated **in-patient** prosthetic rehabilitation program (i.e., beds allocated for clients with amputations), or are these clients admitted under another program?

- Dedicated in-patient program
- Clients admitted under a specific in-patient rehabilitation program (e.g., musculoskeletal)
- Clients admitted under a general in-patient rehabilitation program

- To the best of your knowledge, how long is **in-patient** prosthetic rehabilitation (from being fitted to discharge) at your facility for the following types of clients with lower limb amputation?

	Unilateral transtibial	Unilateral transfemoral	Bilateral transtibial	Bilateral transfemoral
1–3 wk				
4–6 wk				
7–9 wk				
10–12 wk				
>12 wk				

- To the best of your knowledge, how many clients with lower limb amputation are admitted annually as **in-patients** to your facility?

- To the best of your knowledge, how many of the clients you mentioned in question 4 are fitted with a prosthesis?

- To the best of your knowledge, how many clinicians (full time or part time) in your facility provide **in-patient** lower limb prosthetic rehabilitation?

- Does your facility provide **outpatient** rehabilitation services to the clients with lower limb amputation?

☐ Yes ☐ No If no → Skip questions 8–12

- Does your facility have a dedicated **outpatient** prosthetic rehabilitation program, or are these clients serviced under another program?

- Dedicated outpatient program
- Clients serviced under a specific outpatient rehabilitation program (e.g., musculoskeletal)
- Clients serviced under a general outpatient rehabilitation program

- To the best of your knowledge, how long is **outpatient** prosthetic rehabilitation (from being fitted to discharge) at your facility for the following types of clients with lower limb amputation?

	Unilateral transtibial	Unilateral transfemoral	Bilateral transtibial	Bilateral transfemoral
1–3 wk				
4–6 wk				
7–9 wk				
10–12 wk				
>12 wk				

- To the best of your knowledge, how many clients with lower limb amputation are serviced annually as **outpatients** in your facility?

- To the best of your knowledge, how many of the clients you mentioned in question 10 are fitted with a prosthesis?

12. To the best of your knowledge, how many clinicians (full time or part time) in your facility provide **out-patient** lower limb prosthetic rehabilitation?

13. Are the following typically provided in the lower limb prosthetic rehabilitation program in your facility?

Flexibility and range of motion (muscle stretching)	Yes	No
Muscle strengthening	Yes	No
Cardiovascular training (aerobic fitness training)	Yes	No
Balance and coordination	Yes	No
Gait training	Yes	No
Support groups	Yes	No
Prosthetic fit education (skin care, bandaging)	Yes	No
Graduated return to work program	Yes	No
Recreational program (e.g., learning how to ride a bike)	Yes	No
Other → please specify	Yes	No

14. Are clients of these age ranges serviced/admitted to the lower limb prosthetic rehabilitation in your facility?

12 years of age and younger	Yes	No
13–19 y of age	Yes	No
20–49 y of age	Yes	No
50–64 y of age	Yes	No
65+ y of age	Yes	No

15. Are the following health care providers part of your prosthetic rehabilitation team?

Physical therapist	Yes	No
Occupational therapist	Yes	No
Physiatrist	Yes	No
Prosthetist	Yes	No
Nurse	Yes	No
Social worker	Yes	No
Psychologist	Yes	No
Recreational therapist	Yes	No
Vocational therapist	Yes	No
Dietician	Yes	No
Pharmacist	Yes	No
Other → please specify	Yes	No