

**PCC #:** \_\_\_\_\_

**BILL TO:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**SHIP TO:**  SAME AS BILLING \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**SHIPPING:**  GROUND (FXGD)  STANDARD 2 DAY (FX2D)  
 OVERNIGHT:  PRIORITY (FX1D)  1st OVERNIGHT (FX1A)  
 OTHER: \_\_\_\_\_

**CLINICIAN:** \_\_\_\_\_

**CELL #:** \_\_\_\_\_

**PATIENT ID:** \_\_\_\_\_

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

MALE  FEMALE  
 LEFT  RIGHT  BILATERAL

**ENCOUNTER #:** \_\_\_\_\_

**MEASUREMENT DATE:** \_\_\_\_\_

**IN-OFFICE REQUEST DATE & TIME:** \_\_\_\_\_

PROJECT NEWTON (Credit applied on prior auth. denial, details on One Hanger)

**HFN:**  HOUSTON  OTHER \_\_\_\_\_

**ACTIVITY LEVEL (Check one)**

- Limited ambulator: sit to stand and transfer
- Household ambulator: level surfaces with walking aids
- Limited community ambulator: level surfaces with walking aids
- Active community ambulator: mild inclines and declines with or without walking aids
- Independent ambulator: varied cadence, uneven surfaces and no walking aids
- Active ambulator: walking, running, some athletic activity

**OPTION**

- Inner Boot

[Check Brace Fitting & Casting Quick Guide](#)

**CAST EVALUATION**

- Side**  Left  Right \_\_\_\_\_"  Correct  Leave as Cast
- Rotation**  OK  Int  Ext \_\_\_\_\_°  Correct  Leave as Cast
- Fore Foot**  OK  Inv  Evr \_\_\_\_\_"  Correct  Leave as Cast
- Rocker**  OK  Flat  Contoured  Correct  Leave as Cast

**GUIDANCE**

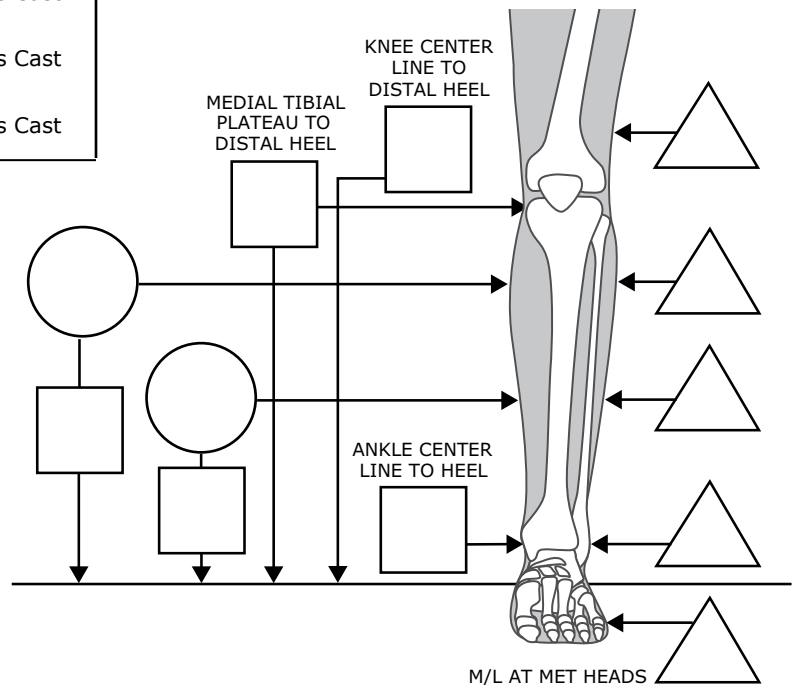
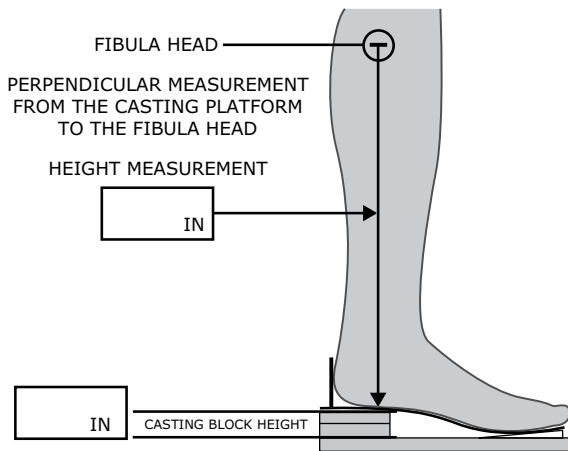
- Any brace with a flat toe plate will require shoe work to function
- Any brace without a contoured foot plate/toe ramp is prone to fail

**REQUIREMENTS**

- Shoe insert or tracing
- Check orthosis fitting prior to final fabrication

**Check List**

- Patients shoe shipped with cast (preferred)
- Tracing of shoe insole provided with order form
- No reference provided (forefoot segment will be made large and will require adjustment by clinician)
- Use fiberglass for AFO section  Use plaster for anterior shell on check orthosis



**LAB USE ONLY**

**Spring Category** (Strut length may change due to final design)  
 .5  .75  1  2  3  4  5  6  7

**Spring Length**

200mm  250mm  300mm

**TURNAROUND TIMES**

To review current projected turnaround times for fabrication sites visit the [Daily HFN Capacity Webpage](#)

**PCC #:** \_\_\_\_\_

**BILL TO:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**SHIP TO:**  SAME AS BILLING \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

\_\_\_\_\_

**SHIPPING:**  GROUND (FXGD)  STANDARD 2 DAY (FX2D)  
 OVERNIGHT:  PRIORITY (FX1D)  1st OVERNIGHT (FX1A)  
 OTHER: \_\_\_\_\_

**CLINICIAN:** \_\_\_\_\_

**CELL #:** \_\_\_\_\_

**PATIENT ID:** \_\_\_\_\_

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

MALE  FEMALE  
 LEFT  RIGHT  BILATERAL

**NG ENCOUNTER #:** \_\_\_\_\_

**MEASUREMENT DATE:** \_\_\_\_\_

**IN-OFFICE REQUEST DATE & TIME:** \_\_\_\_\_

PROJECT NEWTON (Credit applied on prior auth. denial, details on One Hanger)

**HFN:**  HOUSTON  OTHER \_\_\_\_\_

**PRE-WORK CONFIRMATION**

**Was the Check Brace Modified?**  
 No  Yes (indicate modifications)\*  
 Heat Relieve  Pad  Trim

**Patient was Evaluated Walking in Check Brace?**  
 Yes, Please Move to Definitive Device.  
 No, Contact Me Before Moving Forward.

**I am Satisfied with the Check Brace Fit (including modifications if listed).**  
 Yes, Please Move to Definitive Device.  
 No, Contact Me Before Moving Forward.

**BRACE DESIGN/SPECIFICATIONS**

**Cuff Style**

PTB  Anterior Overlap  
 Other \_\_\_\_\_

**Cuff Materials**

ProFlex  1/8" Black Ice Lined

**Closure Type**

BOA  Strap  
 Other \_\_\_\_\_

**Footplate**

Inner Boot  1/8" Black Ice Lined  
 Toe Filler

**Trimlines**

Malleolar Tabs  Toe Lip

**Finish**

Carbon  Custom Fabric Provided

**BOA Dial Location**

Posterior  Lateral

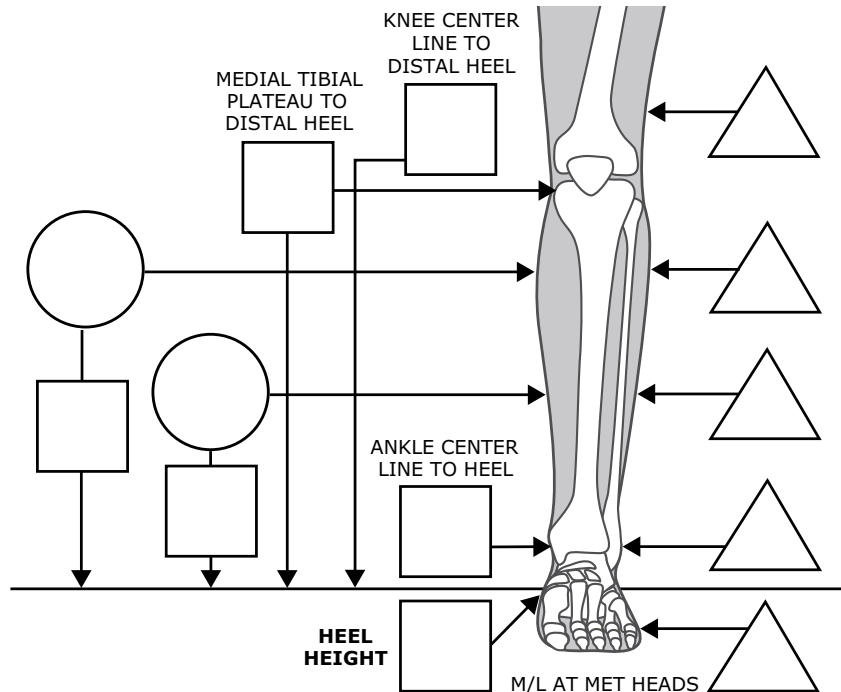
**REQUIREMENTS**

**WEIGHT**

\_\_\_\_\_

**ACTIVITY LEVEL**

Low  
 Medium  
 High



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