HFN

# HIPRO AFO
## Part A: Check Orthosis

**WORK ORDER #:**
(LAB USE ONLY)

**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:** _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

DIAGNOSIS: _____

**AFFECTED SIDE (Check One):**
☐ LEFT ☐ RIGHT or ☐ BILATERAL: SYMMETRICAL ☐ YES ☐ NO

NG ENCOUNTER #: _____

MEASUREMENT DATE: _____

IN-OFFICE REQUEST DATE & TIME: _____

**HiPro is not available digitally. Please ship cast directly to HFN Houston** 3620 Willowbend Blvd, Ste 1118-A | Houston, TX 77054 **HFN:** ☐ HOUSTON

Check Brace Fitting & Casting Quick Guide

## ACTIVITY LEVEL (Check one)

☐ Limited ambulator: sit to stand and transfer
☐ Household ambulator: level surfaces with walking aids
☐ Limited community ambulator: level surfaces with walkng 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

## OPTIONS

☐ Inner Boot ☐ Anterior Shell

## CAST EVALUATION

**Side** **Heel Height**
☐ 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

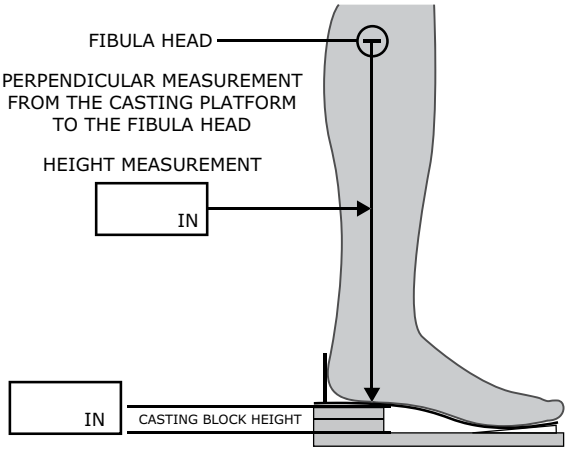
- **Any brace with a flat toe plate will require shoe work to function**
- **Any brace without a contoured foot plate/toe ramp is prone to fail**

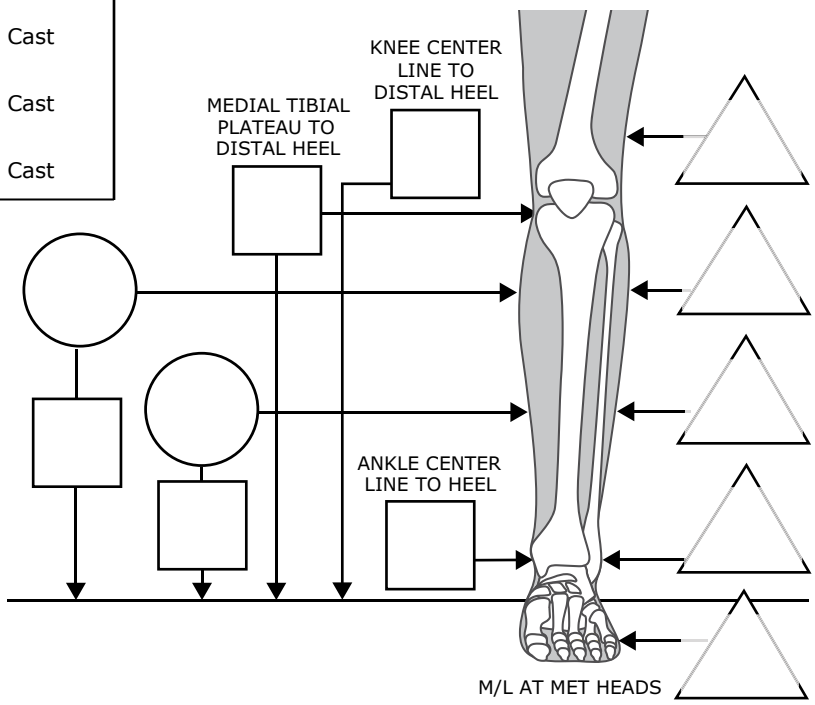
## REQUIREMENTS

- **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.

HFN

# HIPRO AFO
Part B: Definitive

**WORK ORDER #:**
(LAB USE ONLY)

**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:** _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

DIAGNOSIS: _____

**AFFECTED SIDE (Check One):**
☐ LEFT ☐ RIGHT or ☐ BILATERAL: SYMMETRICAL ☐ YES ☐ NO

NG ENCOUNTER #: _____

MEASUREMENT DATE: _____

IN-OFFICE REQUEST DATE & TIME: _____

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## 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 (F9036) ☐ 1/8" Black Ice Lined

**Closure Type**
☐ Adjustable Reel ☐ Strap
☐ Other _____

**Footplate**
☐ Inner Boot ☐ 1/8" Black Ice Lined
☐ Toe Filler

**Trimlines**
☐ Malleolar Tabs ☐ Toe Lip

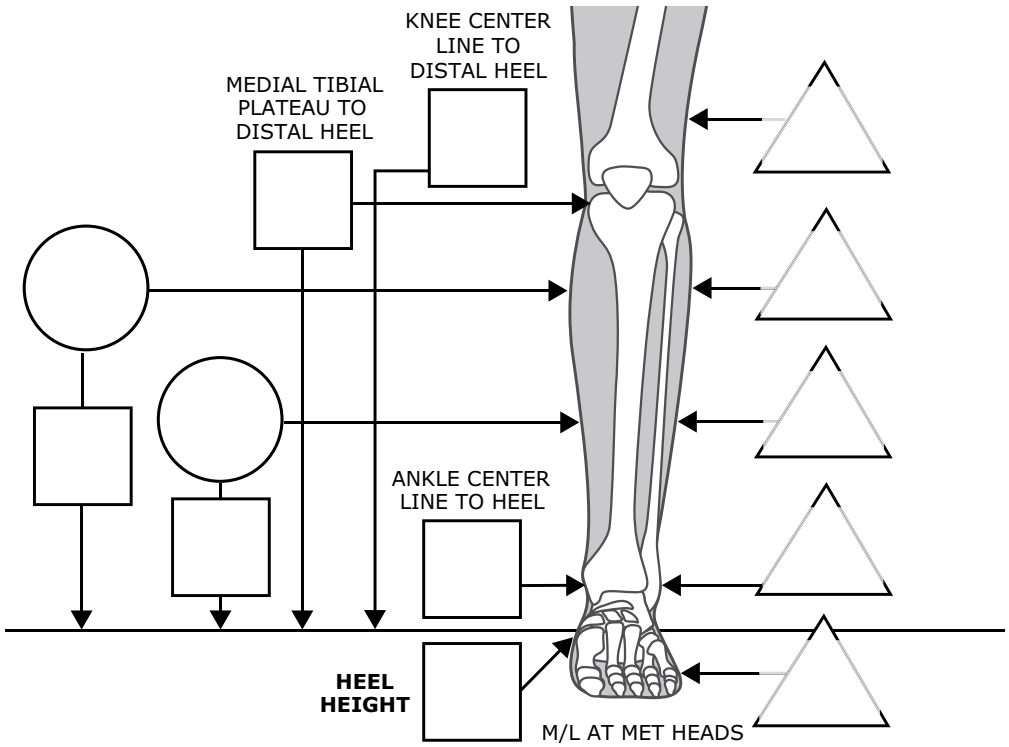
**Finish**
☐ Carbon ☐ Custom Fabric Provided

**Adjustable Reel Location**
☐ Posterior ☐ Lateral

## REQUIREMENTS

**WEIGHT**

**ACTIVITY LEVEL**
**Low**
**Medium**
**High**

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**Spring Length**
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