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 ID: _____

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 ☐ OTHER _____

[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

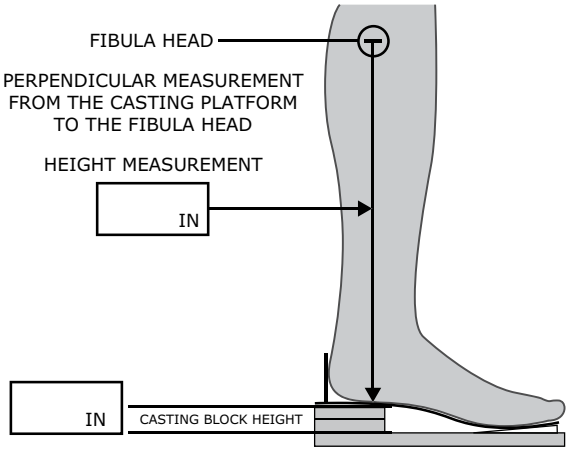
- **Any brace with a flat toe plate will require shoe work to function**
- **Any brace without a contoured foot plate/toe ramp is prone to fail**

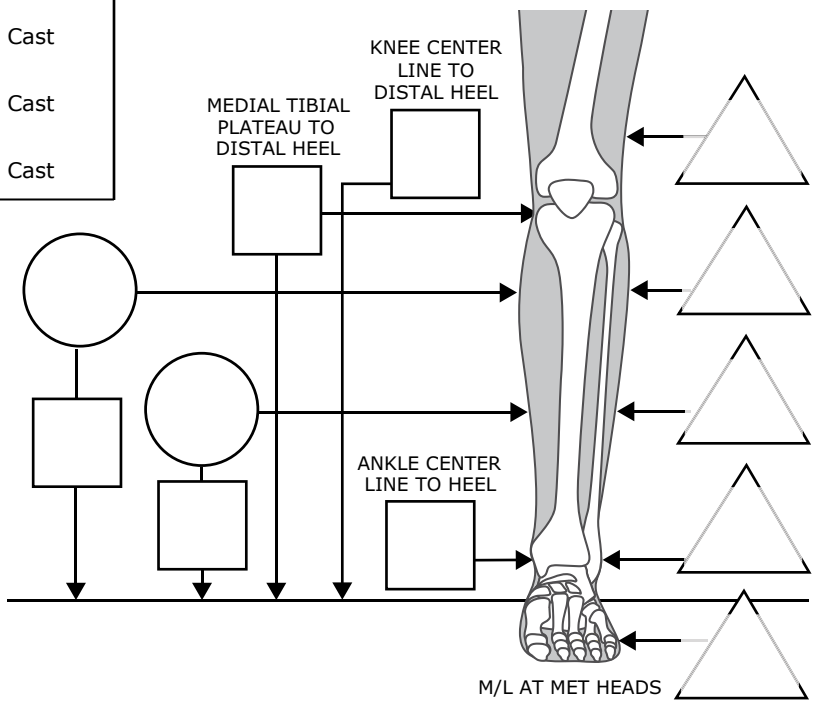
REQUIREMENTS

- **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 ID: _____

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

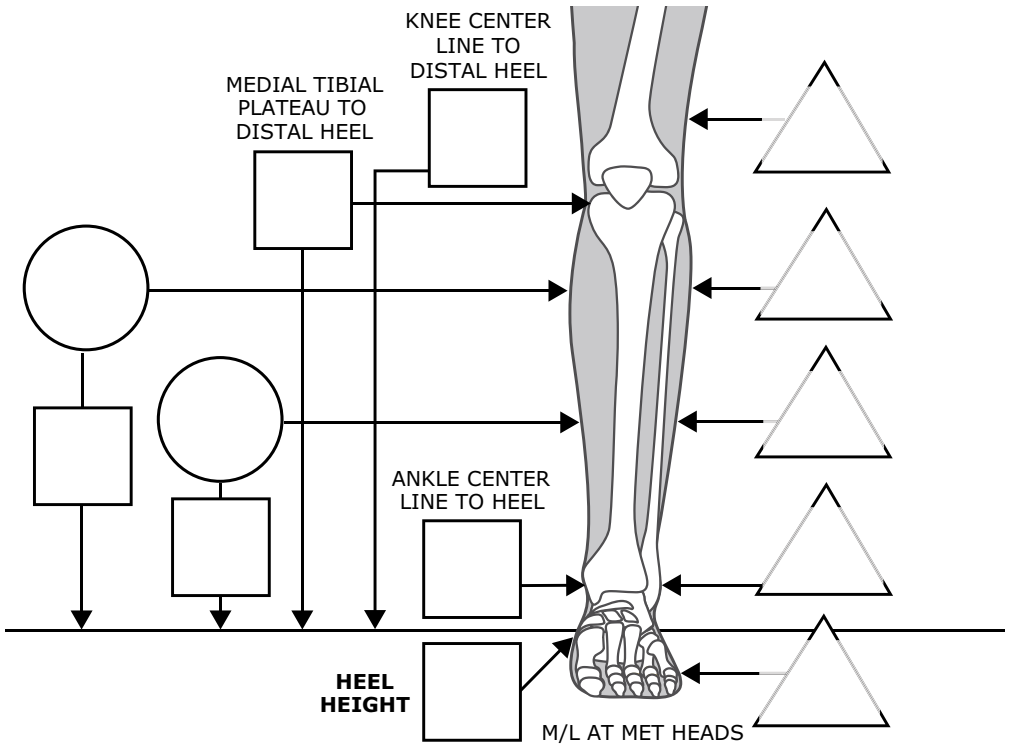
Finish
☐ Carbon ☐ Custom Fabric Provided

Adjustable Reel Location
☐ Posterior ☐ Lateral

REQUIREMENTS

WEIGHT

ACTIVITY LEVEL
Low
Medium
High



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