

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

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 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

OPTIONS

- Inner Boot Anterior Shell

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

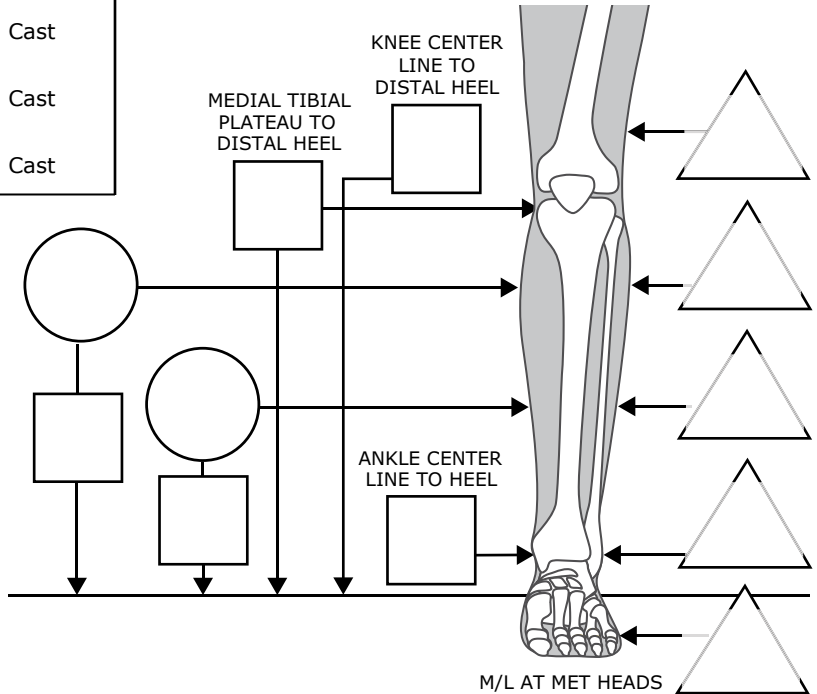
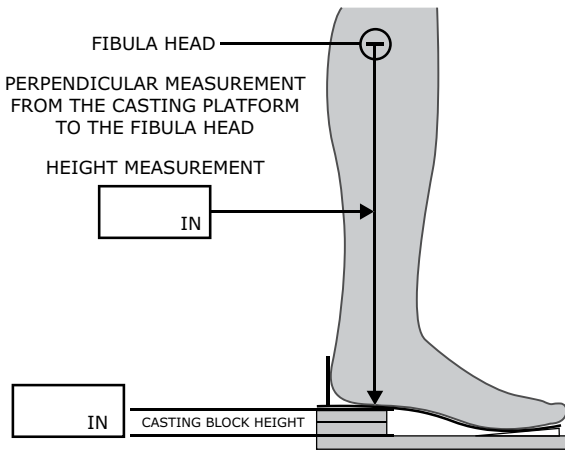
Rocker OK Flat Contoured Correct Leave as Cast

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](#).

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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

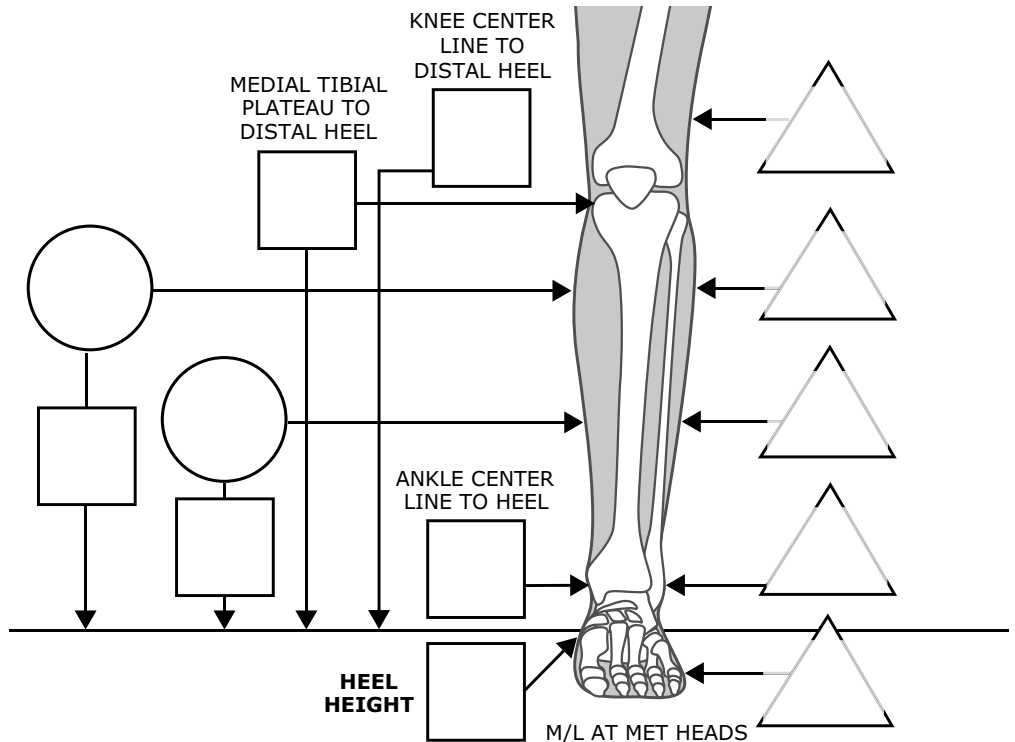
REQUIREMENTS

WEIGHT



ACTIVITY LEVEL

- Low
- Medium
- High



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