

Date: _____ PO#: _____ Account#: _____

Doctor: _____

Address: _____

City: _____ State/Zip: _____ Telephone: _____

PATIENT NAME: _____

Dx: _____ Med Rec #: _____

For PROLAB office use only

Asymmetric Feet? Yes No Male Female Age: _____ Weight (required): _____ Shoe Size _____ Shoe Enclosed

CUSTOM FUNCTIONAL AFO Cast requirement: Non-weightbearing cast

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| <p>PART 1A</p> <p>BRACES</p> <p><input type="checkbox"/> FUNCTIONAL AFO</p> <p><input type="checkbox"/> DORSIFLEXION ASSIST AFO</p> <p><input type="checkbox"/> FUNCTIONAL KIDDY AFO For those wearing children's shoe sizes</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Pair</p> <p><i>Use two Rx forms when prescribing a pair with different prescriptions for each foot.</i></p> | <p>PART 1B</p> <p><input type="checkbox"/> POST. TIBIALIS DYSFUNCTION Pivot flexible, 35mm heel cup, medial flange, standard cast fill, 6mm heel skive <input type="checkbox"/> Sweet Spot (mark on cast)</p> <p><input type="checkbox"/> LATERAL ANKLE INSTABILITY Pivot flexible, 35mm heel cup, wide width, standard cast fill, 3° valgus extension</p> <p><input type="checkbox"/> DJD ANKLE / STJ Pivot fixed¹, 35mm heel cup, medial flange, standard cast fill Requires use of heel-to-toe rocker shoe</p> <p><input type="checkbox"/> DROPFOOT - DF ASSIST³ Dorsiflexion Assist pivot, 35mm heel cup, wide width, standard cast fill</p> | <p>PATHOLOGY SPECIFIC AFO'S</p> <p><input type="checkbox"/> ACHILLES TENDINITIS Pivot fixed¹, 10mm heel cup, wide width, maximum cast fill, 3mm heel lift</p> <p><input type="checkbox"/> PERONEAL TENDINITIS Pivot flexible, 35mm heel cup, wide width, standard cast fill, 3° valgus extension</p> <p><input type="checkbox"/> TARSAL COALITION Pivot fixed¹, 14mm heel cup, wide width, standard cast fill Requires use of heel-to-toe rocker shoe</p> <p><input type="checkbox"/> DROPFOOT - FIXED HINGE³ (for elderly, frail or less than 100lb) Pivot fixed¹, 35mm heel cup, medial flange, standard cast fill Requires use of heel-to-toe rocker shoe</p> | | <p><input type="checkbox"/> CHARCOT FOOT Pivot fixed¹, 35mm heel cup, wide width, maximum cast fill, lateral flange, diabetic topcover Requires use of heel-to-toe rocker shoe</p> <p><input type="checkbox"/> ABDUCTED FOOT Pivot flexible, 35mm heel cup, medial flange, standard cast fill, lateral flange</p> <p><input type="checkbox"/> SEVERE PEDIATRIC FLATFOOT Pivot flexible, 35mm heel cup, medial flange, minimum cast fill, 6mm heel skive</p> |
| | | <p>Only complete Parts 2 or 3 if you want to modify the pathology specific recommendation.</p> | | |

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| <p>PART 2</p> <p>PIVOT</p> <p><input type="checkbox"/> Functional Flex² <input type="checkbox"/> Fixed¹ <input type="checkbox"/> Dorsiflexion Assist³</p> | <p>HEELCUP DEPTH</p> <p><input type="checkbox"/> 35mm <input type="checkbox"/> _____ mm</p> | <p>WIDTH</p> <p><input type="checkbox"/> Wide <input type="checkbox"/> Medial Flange</p> <p>Malleolar width (from med to lat tip) _____ cm</p> | <p>CAST FILL</p> <p><input type="checkbox"/> Minimum <input type="checkbox"/> Standard <input type="checkbox"/> Maximum</p> <p><i>Min = Higher Arch Max = Lower Arch</i></p> | <p>MEDIAL SKIVE</p> <p>(2, 4 or 6 mm) _____ mm</p> | <p>INVERSION</p> <p>_____ ° Max 5°</p> | <p>REQUIRED CLINICAL INFORMATION</p> <p>Diagnosis: _____</p> <p>Did you mark the malleoli? <input type="checkbox"/> Yes</p> <p>Is the knee stable in gait? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the leg to ground angle greater than 10 degrees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it due to: <input type="checkbox"/> Valgum <input type="checkbox"/> Varum _____ °</p> <p>Is equinus present? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ °</p> <p>Is the subtalar joint subluxed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is RCSP greater than 10° everted in stance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>In stance, how far off the ground is the most distal aspect of the medial malleolus? _____ mm</p> <p>Is the subtalar joint: <input type="checkbox"/> Rigid / Fused <input type="checkbox"/> Mobile</p> <p>Is the forefoot abducted in stance? <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</p> |
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| <p>PART 3</p> <p>TOPCOVER</p> <p><input type="checkbox"/> To Mets <input type="checkbox"/> To Sulcus (default) <input type="checkbox"/> To Toes</p> <p><input type="checkbox"/> EVA (standard) <input type="checkbox"/> Diabetic (tri-laminated)</p> <p>Glue Cover Posterior Half Only <input type="checkbox"/></p> | <p>FOREFOOT EXTENSIONS (Sulcus Wedges)</p> <p><input type="checkbox"/> Valgus _____ ° <input type="checkbox"/> Varus _____ ° <input type="checkbox"/> Zero °</p> <p><input type="checkbox"/> Cushioned Extension (Poron™)</p> | <p>SPECIAL ADDITIONS</p> <p><input type="checkbox"/> Heel Lift <input type="checkbox"/> Reverse Morton's Ext. <input type="checkbox"/> Morton's Extension <input type="checkbox"/> Lateral Flange <input type="checkbox"/> Sweet Spot Mark location on cast and drawing below.</p> |
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SPECIAL INSTRUCTIONS

Standard Shipping
 Fedex Ground



LAB USE ONLY

Doctor's Signature _____

- RESTRICTIONS:**
- Not recommended if significant equinus present. Patient must be able to get heel to ground
 - Malleoli must be marked on cast for brace to be manufactured
 - Do not use this AFO with patients over 250lbs or over 6'2" tall

- NOTES:**
- ¹ Fixed pivot braces must be used in a heel-to-toe rocker bottom shoe
Fixed pivot can be converted to flexible pivot
 - ² Flexible pivots can be converted to fixed pivots
 - ³ Not to be used with significant equinus (must be able to get heel to ground), spasticity of medial posterior lower leg muscles, or plantarflexor weakness
 - ⁴ If the foot is less than 10° plantarflexed, add heel lift (5mm to 9mm)