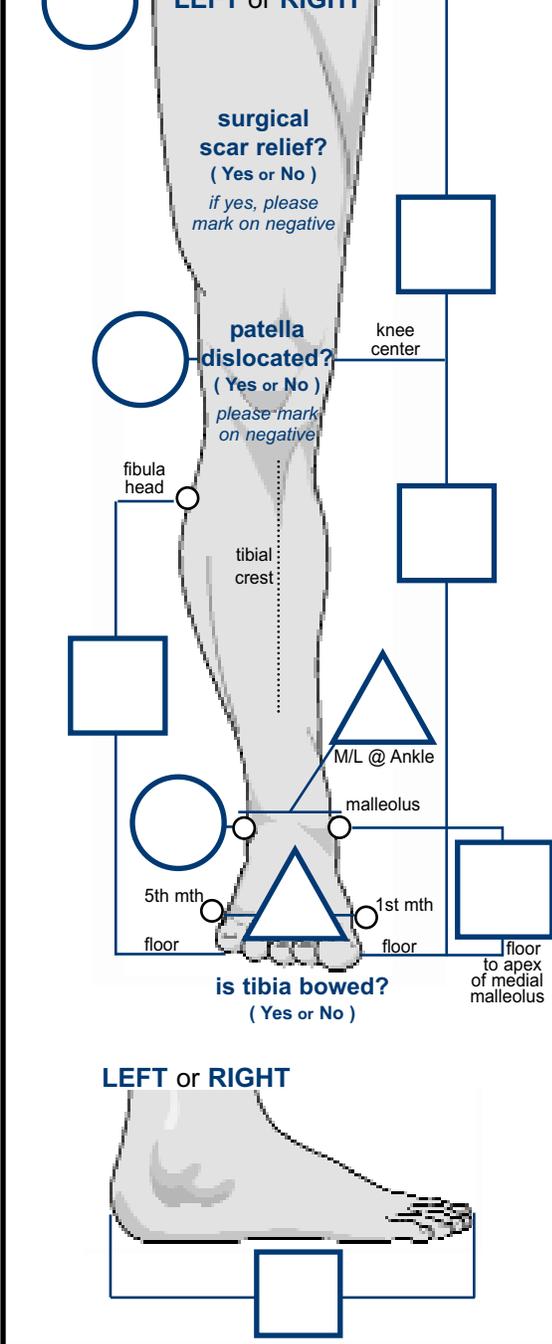


BILL TO: _____ **Practitioner:** _____ **P.O.#** _____
O&P Facility: _____ **E-Mail:** _____
Address: _____ **Ship To (if different):** _____ **Shipping Method:**
 UPS Ground (No Charge)
 3 Day Ground
 Blue
 Red
 Red Early
City: _____ **Address:** _____
State: _____ **ZIP:** _____ **City:** _____
State: _____ **ZIP:** _____

Patient: _____ **Ht:** _____ **Wt:** _____ **Age:** _____ **LOM (in degrees):** _____
Primary Dx: _____ **Affected Limb's Skin Integrity (circle one)** **POOR** **FAIR** **GOOD**
Secondary Dx: _____ **Affected Limb's Circulation (circle one)** **POOR** **FAIR** **GOOD**
Affected Limb's Sensation (circle one) **POOR** **FAIR** **GOOD**

ATTN: BEFORE CASTING, PLEASE REVIEW CONSIDERATIONS
(located on reverse side)



Notes: _____
 _____ (M/L) _____ (M/L)

ANKLE	KNEE	CLOSURES
CONFIGURATION: <input type="checkbox"/> "T" stirrup <input type="checkbox"/> lively subtalar pivot <input type="checkbox"/> free motion <input type="checkbox"/> neutral lockout <input type="checkbox"/> progressive I/out MEDIAL: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit dorsiflexion <input type="checkbox"/> limit plantarflexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> dorsiflexion assist <input type="checkbox"/> plantarflexion assist LATERAL: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit dorsiflexion <input type="checkbox"/> limit plantarflexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> dorsiflexion assist <input type="checkbox"/> plantarflexion assist <p align="center"><i>please record all measurements in inches</i></p>	MEDIAL: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit extension <input type="checkbox"/> limit flexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> extension assist <input type="checkbox"/> flexion assist LATERAL: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit extension <input type="checkbox"/> limit flexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> extension assist <input type="checkbox"/> flexion assist 	THIGH: <input type="checkbox"/> hinged <input type="checkbox"/> non-hinged <input type="checkbox"/> rigid <input type="checkbox"/> flexible <input type="checkbox"/> straps/pads TIBIAL: <input type="checkbox"/> hinged <input type="checkbox"/> non-hinged <input type="checkbox"/> rigid <input type="checkbox"/> flexible <input type="checkbox"/> straps/pads FOOT: <input type="checkbox"/> hinged <input type="checkbox"/> non-hinged <input type="checkbox"/> rigid <input type="checkbox"/> flexible <input type="checkbox"/> straps/pads <input type="checkbox"/> heel <input type="checkbox"/> midfoot <input type="checkbox"/> forefoot FOOTPLATE MODS: <input type="checkbox"/> anatomical <input type="checkbox"/> tone reducing <input type="checkbox"/> SMO insert FOOTPLATE BOTTOM: <input type="checkbox"/> non-skid <input type="checkbox"/> crepe sole
Does the joint need to allow for hyperextension? (Yes or No) Is there equinovarus deformity? (Yes or No) If yes, can it be corrected in the negative? (Yes or No) Is the patient ambulating in brace? (Yes or No) Migration prevention mods? (Yes or No) (purchase mods at epicondyles, post. gastroc suspension strap)		

PLASTIC: Blue HDPE (standard) .140 - .187
HDPE: Yellow.140 Black.140, .187 Red.140 White.140, .187 Pink.125 Purple.125 Black White
POLYPRO .187: Black White
STRAPS: Black White
FOAM: 1/4" (standard) 1/8" 3/8"

Casting Considerations for Ultraflex Custom Molded Orthoses

LOWER EXTREMITY

- 1) Patient evaluation should generally follow ABC “SOAP” procedures - Subjective, Objective, Assessment, & Plan and specifically follow the Ultraflex Manual-Catalog. Note: evaluations & orthoses designs differ for ortho & neuro patients.
- 2) Document all anatomic landmarks & measurements noted on Ultraflex Custom Fabrication Order Form.
- 3) Cast affected limb, maximizing levers inferior & superior to joint, spanning 2/3 to 3/4 of each limb segment. Note areas of open wounds, skin grafts, etc... (that require relief or modification) directly on cast stockinette.
- 4) Introduce gentle hand pressure to extend or flex the limb (as applicable) in the direction of intended correction. For cases requiring both flexion & extension correction, cast in a comfortable mid-range position.
- 5) Place casting tube opposite of where intended shells will provide force (to minimize obscuring anatomy at points of body interface). For example, on a flexion assist KO, place tube on posterior aspect for an anterior shell brace design.

Please note the recommended limb postures for certain orthoses types:

AFO - subtalar & rearfoot neutral (plantarflexed as necessary to achieve this)

BKA - mark all boney prominences & healing wound areas

KAFO - for neuro cases with gastroc involvement, flexing knee may help achieve better ankle posture for subtalar & rearfoot neutral with greater dorsi-flexion (assuming design is to extend knee and dorsiflex ankle as would be required for tight hamstrings, gastroc & soleus muscles.)

Orthopedic

Knee in midrange with ankle plantarflexed with subtalar neutral



Neurological

Knee in midrange with ankle subtalar neutral to extent feasible



Call Ultraflex Clinical Technical Support at 1-800-220-6670 for any questions.