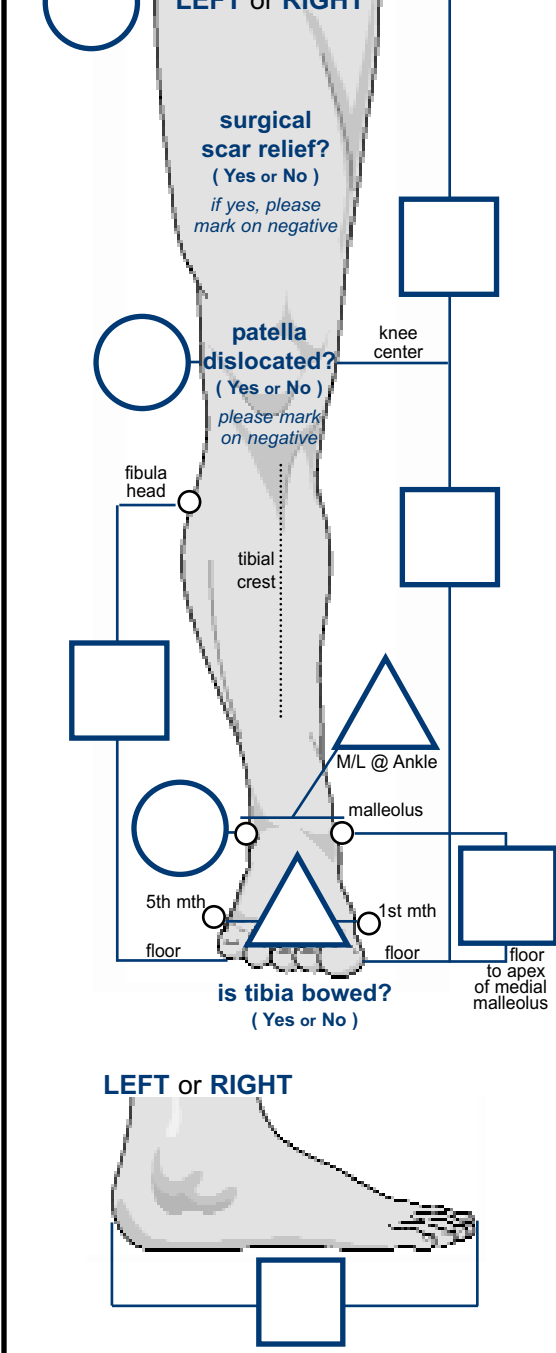


BILL TO: _____	Practitioner: _____	P.O.# _____
O&P Facility: _____	E-Mail: _____	Shipping Method: <input type="checkbox"/> UPS Ground (No Charge) <input type="checkbox"/> 3 Day Ground <input type="checkbox"/> Blue <input type="checkbox"/> Red <input type="checkbox"/> Red Early
Address: _____	Ship To (if different): _____	
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	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: <input type="checkbox"/> Blue HDPE (standard) .140 - .187 HDPE: <input type="checkbox"/> Yellow.140 <input type="checkbox"/> Black.140, .187 <input type="checkbox"/> Red.140 <input type="checkbox"/> White.140, .187 <input type="checkbox"/> Pink.125 <input type="checkbox"/> Purple.125	POLYPRO .187: <input type="checkbox"/> Black <input type="checkbox"/> White	STRAPS: <input type="checkbox"/> Black <input type="checkbox"/> White	FOAM: <input type="checkbox"/> 1/4" (standard) <input type="checkbox"/> 1/8" <input type="checkbox"/> 3/8"
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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.