

COMPANY: _____

ACCOUNT NO.: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY, STATE, ZIP: _____

PRACTITIONER: _____

PHONE: _____

EMAIL: _____

PURCHASE ORDER: _____

PATIENT ID: _____

INITIAL INTAKE

Age	Height	Weight	Sex	Diagnosis
	<input type="checkbox"/> in. <input type="checkbox"/> cm	<input type="checkbox"/> lbs. <input type="checkbox"/> kg	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Lower Extremity Range of Motion				
Contracture(s)		Left Side	Right Side	
ANKLE		<input type="checkbox"/> No <input type="checkbox"/> Yes Degree:	<input type="checkbox"/> No <input type="checkbox"/> Yes Degree:	
KNEE		<input type="checkbox"/> No <input type="checkbox"/> Yes Degree:	<input type="checkbox"/> No <input type="checkbox"/> Yes Degree:	
HIP		<input type="checkbox"/> No <input type="checkbox"/> Yes Degree:	<input type="checkbox"/> No <input type="checkbox"/> Yes Degree:	
Contraindications to Consider				
<input type="checkbox"/> Severe irreducible contractures that prevent establishing normal alignment. <input type="checkbox"/> Spasticity or other involuntary muscle activity that prevents free and coordinated mobility. <input type="checkbox"/> Obesity <input type="checkbox"/> Poor upper extremity strength.				Contact Fillauer to discuss.

PELVIC SECTION

Reciprocator	<input type="checkbox"/> Horizontal Cable <input type="checkbox"/> Rocker Bar / Isocentric			
LSO Material	<input type="checkbox"/> Plastic* <input type="checkbox"/> Metal (Foam-lined Bands)			
Plastic LSO Options	Under 85 lbs. (38 kg)	86 – 120 lbs. (39 – 54 kg)	121 – 175 lbs. (55 – 79 kg)	175 – 250 lbs. (80 – 113 kg)
Plastic	<input type="checkbox"/> 1/8 in. ABS* <input type="checkbox"/> 1/8 in. Copolymer**	<input type="checkbox"/> 3/16 in. ABS* <input type="checkbox"/> 5/32 in. Copolymer**	<input type="checkbox"/> 3/16 in. ABS* <input type="checkbox"/> 3/16 in. Copolymer**	
Liner	<input type="checkbox"/> Double 1/4 in. Volara* <input type="checkbox"/> Single 1/4 in. Volara		<input type="checkbox"/> Single 1/4 in. Volara* <input type="checkbox"/> Double 1/4 in. Volara	
Liner / Plastic / Straps Color	<input type="checkbox"/> Black* <input type="checkbox"/> White <input type="checkbox"/> Transfer Part No.:		Distributor:	
Anterior Closure	<input type="checkbox"/> Proximal Strap* <input type="checkbox"/> Apron <input type="checkbox"/> Bivalve			
	Under 85 lbs. (38 kg)	86 – 120 lbs. (39 – 54 kg)	121 – 175 lbs. (55 – 79 kg)	175 – 250 lbs. (80 – 113 kg)
Hip Joint	<input type="checkbox"/> Latch Knob* <input type="checkbox"/> Push Button <input type="checkbox"/> RGO II with Abduction	<input type="checkbox"/> Push Button* <input type="checkbox"/> RGO II with Abduction		
Upper Bars	<input type="checkbox"/> Standard* <input type="checkbox"/> Lengthened			

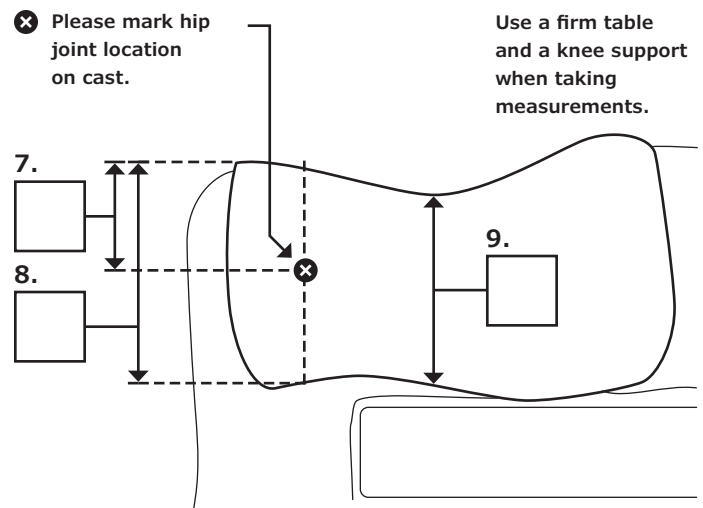
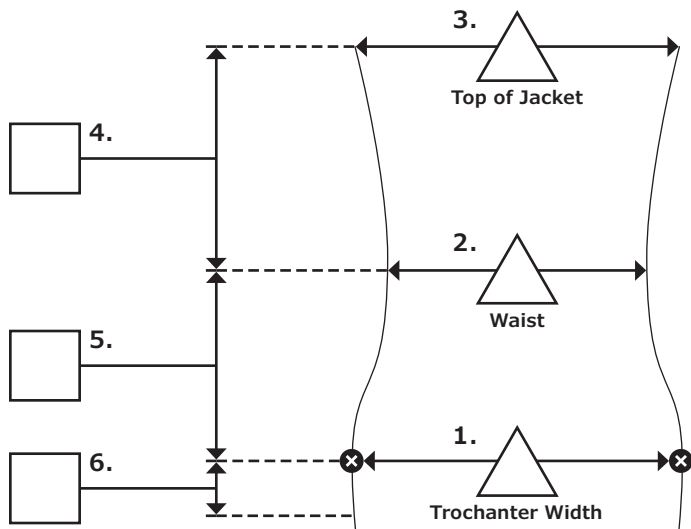
PATIENT MEASUREMENTS Please complete all necessary measurements:

Fill out all 9 measurement boxes on this form. Measurements are needed even when you are sending a cast. If you need a custom design or expert advice, please let us know.

IMPORTANT:

Measurements 1–7 are crucial for a good fit.

Measurements in: ☐ Centimeters ☐ Inches



KAFO

Number of Uprights	<input type="checkbox"/> Double* <input type="checkbox"/> Single			
AFOs	<input type="checkbox"/> Internal* <input type="checkbox"/> External (Cast must be done over the shoe)			
Inner Boot	<input type="checkbox"/> No* <input type="checkbox"/> Yes***			
Knee Joint	<input type="checkbox"/> Becker Drop Lock* <input type="checkbox"/> Becker Drop Lock with Retainers <input type="checkbox"/> StepLock <input type="checkbox"/> InterLock			
Knee Joint Bail	<input type="checkbox"/> Bail for Interlock or Steplock <input type="checkbox"/> Provided by Clinician <input type="checkbox"/> Becker Bail Lock			
	Under 85 lbs. (38 kg)	86 – 120 lbs. (39 – 54 kg)	121 – 175 lbs. (55 – 79 kg)	175 – 250 lbs. (80 – 113 kg)
Plastic	<input type="checkbox"/> 3/16 in. Polypro			<input type="checkbox"/> 1/4 in. Polypro
Upright Material and Size	<input type="checkbox"/> 3/16 × 5/8 in. Al* <input type="checkbox"/> 3/16 × 1/2 in. Al	<input type="checkbox"/> 3/16 × 5/8 in. Al* <input type="checkbox"/> 3/16 × 3/4 in. Al	<input type="checkbox"/> 3/16 × 3/4 in. Al* <input type="checkbox"/> 3/16 × 3/4 in. SS <input type="checkbox"/> 1/4 × 3/4 in. Al	<input type="checkbox"/> 3/16 × 3/4 in. SS* <input type="checkbox"/> 1/4 × 3/4 in. Al <input type="checkbox"/> 1/4 × 1 in. Al
Growth Extension on thigh	<input type="checkbox"/> Yes* <input type="checkbox"/> No	<input type="checkbox"/> No		
Ankle	<input type="checkbox"/> Solid Ankle without Reinforcement* <input type="checkbox"/> Solid Ankle with Reinforcement <input type="checkbox"/> Fillauer Double Action*** <input type="checkbox"/> Provided by Clinician***	<input type="checkbox"/> Solid Ankle with Reinforcement* <input type="checkbox"/> Solid Ankle without Reinforcement <input type="checkbox"/> Fillauer Double Action*** <input type="checkbox"/> Provided by Clinician***		

OPTIONS (ADDITIONAL CHARGE)

- | | | |
|--|--|--|
| <input type="checkbox"/> Nighttime AFO (Copolymer) | <input type="checkbox"/> Crepe buildup or wedging per side per $\frac{1}{2}$ in. over $\frac{1}{2}$ in. on External AFO only | <input type="checkbox"/> Growth Extension below the knee |
| <input type="checkbox"/> Pretibial shell (PE) | <input type="checkbox"/> DCO (Diagnostic Check Orthosis) | <input type="checkbox"/> Padded legs |
| <input type="checkbox"/> Molded inner boots | | |

All measurements MUST be provided, even when sending a cast.

1. Provide all measurements, especially the M-L diameters taken with a caliper gauge.
2. Supply a profile tracing from axilla to feet.
3. Plaster molds of each extremity are required.
 - Maintain ankle joint in neutral position for low heel shoe.
 - Correct ankle inversion or eversion as much as possible.
 - Reduce knee valgus or varus
 - Use a right angle casting board
4. When a plastic pelvic band is desired, refer to special casting suggestions in the RGO Fabrication Manual.

CAST MOLD CORRECTIONS

ANKLE

Specify up to 10°

- ☐ Please correct forefoot to _____
- ☐ Please correct rearfoot to _____
- ☐ No Corrections, casted in correct position

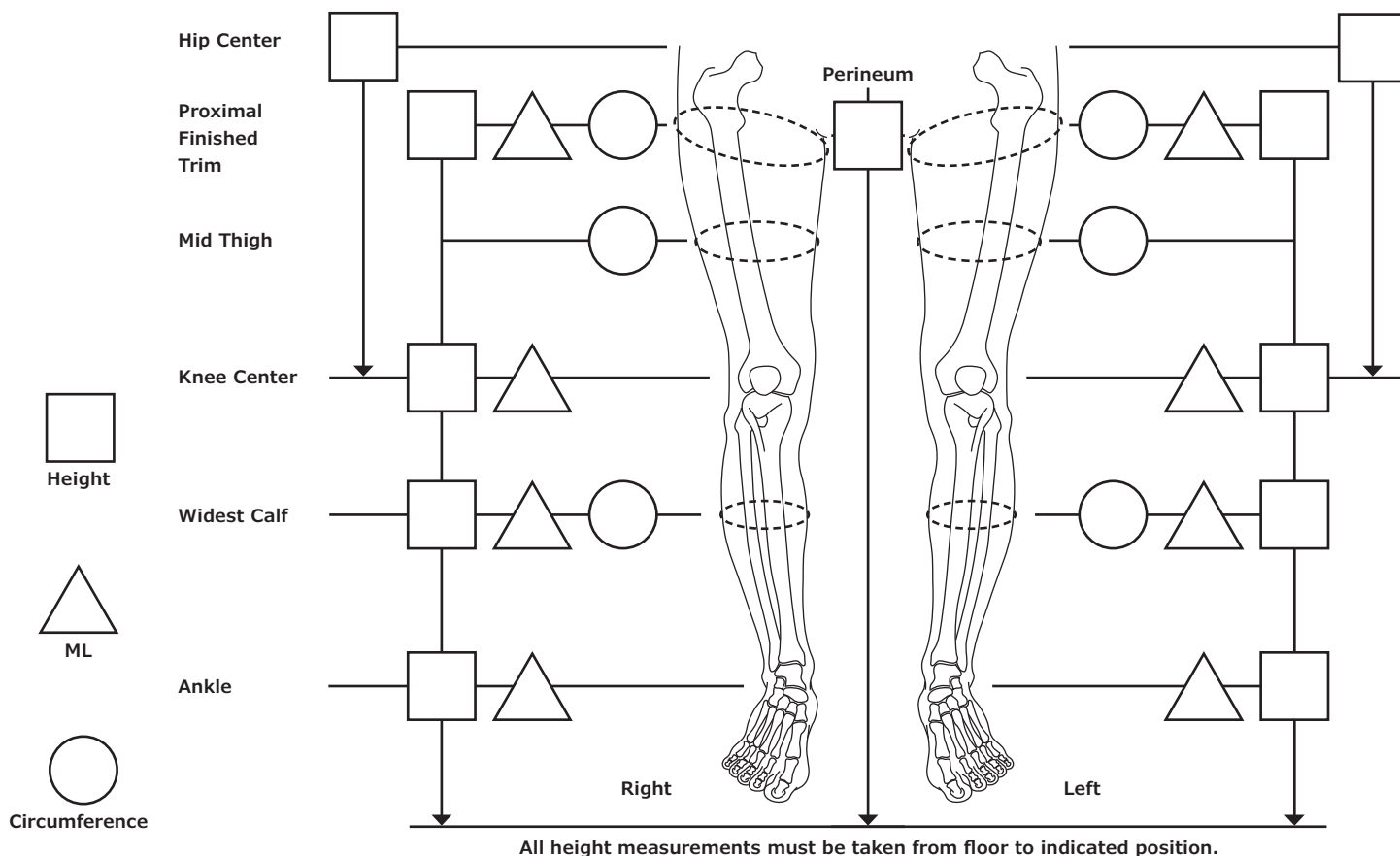
KNEE

Specify up to 10° extension reduction or 20° of flexion reduction

- ☐ Please correct, set knee hinges at 0°
- ☐ Please correct, set knee hinges at _____° of flexion
- ☐ No Corrections, set knee hinges at casted position

ADDITIONAL INSTRUCTIONS

PATIENT MEASUREMENTS Please complete all necessary measurements:



FOOT MEASUREMENTS

