The DiABETiC Shoppe
1068 Factory Drive | Charleston, MS 38921
Toll-Free Phone: 1-888-571-3533 ~ Toll-Free Fax: 1-888-377-2224

Orthosis Treatment and Evaluation Form

Name: _____ DOB: _____

Pain is located in: Back Upper ❑ Lower ❑
Knee Right ❑ Left ❑ Both ❑
Ankle Right ❑ Left ❑ Both ❑
Wrist Right ❑ Left ❑ Both ❑

Have you talked to your dr about this pain? _____

Can we contact your doctor about this item? _____

How did you injure your(_____

PATIENT PROFILE

Ambulation:Independent ❑ Cane ❑ Walker ❑ Wheelchair ❑

Height:_____ Weight _____

Recommendations:

L0631	Back Brace (upper)❑				
L0627	Back Brace (lower)❑				
L1832	Knee Brace ❑	Right ❑	Left ❑	Both ❑	
L1971	Ankle Brace ❑	Right ❑	Left ❑	Both ❑	
L3807	Wrist Brace ❑	Right ❑	Left ❑	Both ❑	
L1951	Drop Foot Device ❑	Right ❑	Left ❑	Both ❑	

Measurements:
Waist (around navel) _____
Thigh (6" above patella) _____
Ankle (shoe size) _____
Wrist (at ulna prominence) _____
Drop Foot Device (shoe size) _____

Notes_____

_____

_____

Clinician Name:_____ **Date:** _____

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