Lantz Medical
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FAX ORDERS TO 877-406-4872

1. Complete Patient Information.
2. Choose Product.
3. Complete measurements, ***in inches***, for desired product.
4. Fax measurements, face sheet (with insurance information) and Rx.

1. PATIENT INFORMATION

Name: _____ **DOB:** _____

3. Measurements

_____ 1 Bicep Circumference (at largest part)

_____ 2 Mid forearm Circumference

_____ 3 Forearm Circumference (at largest part)

_____ 4 Circumference at Wrist Crease

_____ 5 Circumference 1" Proximal to Ulnar Styloid

_____ 6 Circumference 1" Proximal to Elbow Crease

_____ 7 Circumference 1" Distal to Elbow Crease

_____ 8 Length: Mid Elbow Crease to Mid Wrist Crease**

_____ 9 Length: Anterior Crease of Axilla to Medial Epicondyle

_____ 10 Length: Ulnar Styloid to 5th MP Joint

_____ 11 **Width** of Hand at MP Joint

_____ 12 Length: Wrist Crease to end of digit #3

2. Device Needed

☐ **Right** ☐ **Left**

Only measurements listed next to the device being ordered need to be taken. Each number corresponds to a measurement in box 3.

_____ WHFO **3, 5, 8, 10, 11**

_____ Wrist **3, 5, 8, 10, 11, 12**

☐ Please check box if optional anti-spasticity ball is desired. *Splint will be sent without anti-spasticity ball if box is not checked.

_____ Elbow **1, 2, 4, 6, 7, 8, 9, 11**

_____ ESP **1, 2, 4, 6, 7, 8, 9, 11**

_____ Pro/Sup **1, 2, 4, 6, 7, 8, 9, 11**

_____ Shoulder **2, 4, 7, 8**

_____ Knee* **13, 14, 15, 16, 17, 18, 19**

See diagram below for knee measurements.

***When taking this measurement, the patient's elbow should be supinated and flexed at 90°*

Notes/Special Instructions