

Date: \_\_\_\_\_ PO#: \_\_\_\_\_ Account#: \_\_\_\_\_

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Dx: \_\_\_\_\_ Med Rec #: \_\_\_\_\_

For PROLAB  
office use only

Asymmetric Feet?  Yes  No     Male  Female    Age: \_\_\_\_\_    Weight (required): \_\_\_\_\_    Shoe Size \_\_\_\_\_     Shoe Enclosed

## CUSTOM FUNCTIONAL AFO

Cast Requirements:  
A non-weightbearing cast using an STS mid-leg sock.

<p><b>PART 1A</b></p> <p><b>BRACES</b></p> <p><input type="checkbox"/> FUNCTIONAL AFO</p> <p><input type="checkbox"/> DORSIFLEXION ASSIST AFO</p> <p><input type="checkbox"/> FUNCTIONAL KIDDY AFO For those wearing children's shoe sizes</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Pair</p> <p><i>Use two Rx forms when prescribing a pair with different prescriptions for each foot.</i></p>	<p><b>PART 1B</b></p> <p><input type="checkbox"/> POST. TIBIALIS DYSFUNCTION Pivot flexible, 35mm heel cup, medial flange, standard cast fill, 6mm heel skive <input type="checkbox"/> Sweet Spot (mark on cast)</p> <p><input type="checkbox"/> LATERAL ANKLE INSTABILITY Pivot flexible, 35mm heel cup, wide width, standard cast fill, 3° valgus extension</p> <p><input type="checkbox"/> DJD ANKLE / STJ Pivot fixed<sup>1</sup>, 35mm heel cup, medial flange, standard cast fill <b>Requires use of heel-to-toe rocker shoe</b></p> <p><input type="checkbox"/> DROPFOOT - DF ASSIST<sup>3</sup> Dorsiflexion Assist pivot, 35mm heel cup, wide width, standard cast fill</p>	<p><b>PATHOLOGY SPECIFIC AFO'S</b></p> <p><input type="checkbox"/> ACHILLES TENDINITIS Pivot fixed<sup>1</sup>, 10mm heel cup, wide width, maximum cast fill, 3mm heel lift</p> <p><input type="checkbox"/> PERONEAL TENDINITIS Pivot flexible, 35mm heel cup, wide width, standard cast fill, 3° valgus extension</p> <p><input type="checkbox"/> TARSAL COALITION Pivot fixed<sup>1</sup>, 14mm heel cup, wide width, standard cast fill <b>Requires use of heel-to-toe rocker shoe</b></p> <p><input type="checkbox"/> DROPFOOT - FIXED HINGE<sup>3</sup> (for elderly, frail or less than 100lb) Pivot fixed<sup>1</sup>, 35mm heel cup, medial flange, standard cast fill <b>Requires use of heel-to-toe rocker shoe</b></p>		<p><input type="checkbox"/> CHARCOT FOOT Pivot fixed<sup>1</sup>, 35mm heel cup, wide width, maximum cast fill, lateral flange, diabetic topcover <b>Requires use of heel-to-toe rocker shoe</b></p> <p><input type="checkbox"/> ABDUCTED FOOT Pivot flexible, 35mm heel cup, medial flange, standard cast fill, lateral flange</p> <p><input type="checkbox"/> SEVERE PEDIATRIC FLATFOOT Pivot flexible, 35mm heel cup, medial flange, minimum cast fill, 6mm heel skive</p>
		<p><b>Only complete Parts 2 or 3 if you want to modify the pathology specific recommendation.</b></p>		

<p><b>PART 2</b></p> <p><b>PIVOT</b></p> <p><input type="checkbox"/> Functional Flex<sup>2</sup> <input type="checkbox"/> Fixed<sup>1</sup> <input type="checkbox"/> Dorsiflexion Assist<sup>3</sup></p>	<p><b>HEELCUP DEPTH</b></p> <p><input type="checkbox"/> 35mm <input type="checkbox"/> _____ mm</p>	<p><b>WIDTH</b></p> <p><input type="checkbox"/> Wide <input type="checkbox"/> Medial Flange</p> <p>Malleolar width (from med to lat tip) _____ cm</p>	<p><b>CAST FILL</b></p> <p><input type="checkbox"/> Minimum <input type="checkbox"/> Standard <input type="checkbox"/> Maximum</p> <p><i>Min = Higher Arch Max = Lower Arch</i></p>	<p><b>MEDIAL SKIVE</b></p> <p>(2, 4 or 6 mm)</p> <p>_____ mm</p>	<p><b>INVERSION</b></p> <p>_____ ° Max 5°</p>	<p><b>REQUIRED CLINICAL INFORMATION</b></p> <p>Diagnosis: _____</p> <p>Did you mark the malleoli? <input type="checkbox"/> Yes</p> <p>Is the knee stable in gait? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the leg to ground angle greater than 10 degrees? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it due to: <input type="checkbox"/> Valgum <input type="checkbox"/> Varum _____ °</p> <p>Is equinus present? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ °</p> <p>Is the subtalar joint subluxed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is RCSP greater than 10° everted in stance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>In stance, how far off the ground is the most distal aspect of the medial malleolus? _____ mm</p> <p>Is the subtalar joint: <input type="checkbox"/> Rigid / Fused <input type="checkbox"/> Mobile</p> <p>Is the forefoot abducted in stance? <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</p>
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<p><b>PART 3</b></p> <p><b>TOPCOVER</b></p> <p><input type="checkbox"/> To Mets <input type="checkbox"/> To Sulcus (default) <input type="checkbox"/> To Toes</p> <p><input type="checkbox"/> EVA (standard) <input type="checkbox"/> Diabetic (tri-laminated)</p> <p>Glue Cover Posterior Half Only <input type="checkbox"/></p>	<p><b>FOREFOOT EXTENSIONS (Sulcus Wedges)</b></p> <p><input type="checkbox"/> Valgus _____ ° <input type="checkbox"/> Varus _____ ° <input type="checkbox"/> Zero °</p> <p><input type="checkbox"/> Cushioned Extension (Poron™)</p>	<p><b>SPECIAL ADDITIONS</b></p> <p><input type="checkbox"/> Heel Lift <input type="checkbox"/> Reverse Morton's Ext. <input type="checkbox"/> Morton's Extension <input type="checkbox"/> Lateral Flange <input type="checkbox"/> Sweet Spot <b>Mark location on cast and drawing below.</b></p>
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**SPECIAL INSTRUCTIONS**

Standard Shipping  
 Fedex Ground

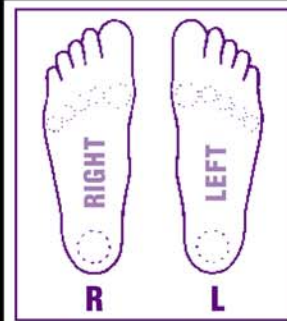
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PLANTAR VIEW

**LAB USE ONLY**

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Doctor's Signature \_\_\_\_\_

**RESTRICTIONS:**

- Not recommended if significant equinus present. Patient must be able to get heel to ground
- Malleoli must be marked on cast for brace to be manufactured
- Do not use this AFO with patients over 250lbs or over 6'2" tall

**NOTES:**

- <sup>1</sup> Fixed pivot braces must be used in a heel-to-toe rocker bottom shoe  
Fixed pivot can be converted to flexible pivot
- <sup>2</sup> Flexible pivots can be converted to fixed pivots
- <sup>3</sup> Not to be used with significant equinus (must be able to get heel to ground), spasticity of medial posterior lower leg muscles, or plantarflexor weakness
- <sup>4</sup> If the foot is less than 10° plantarflexed, add heel lift (5mm to 9mm)