Contents

How to Use the Order Forms

Welcome to Cascade Dafo, Inc., and to a wide choice of brace designs for your patient's comfort, stability, and mobility.

To ensure that we interpret your instructions correctly, please take a little time to examine the form you'll use, especially if you are new to ordering from us.

Each brace style has its own order form that clearly shows the brace and its options. This book contains master copies. Please photocopy the order form you need and fill out the photocopy (not the original).

In each section that shows a **Standard** choice, if you don't check any boxes, we will assume you want the **Standard**.

Patient/Practitioner/Billing/Shipping—For all braces, to have the brace shipped or billed to the same location shown in the Practitioner section, simply check the boxes in the Shipping or Billing sections. You don't need to fill those sections out again. If the brace needs to be billed or shipped to a different facility, be sure to provide that address information.

The following comments apply only to custom bracing from a cast.

Cast Correction • Position of Function—This is the only section that does not assume any standard choice. **This information is essential to the alignment of the brace; make very sure that you complete it.** If you were able to correct the foot adequately during casting, be sure to check the Do Not Correct box.

These choices offer the only clue to desired alignment (besides the cast). Fill out correction information for ankle, hindfoot and forefoot. Indicate posting height in inches or millimeters, and please note which form of measurement you used.

Please also note that we are asking how the finished brace should be aligned, rather than what the cast or foot looks like.

Posterior Height—Cast higher than the final height so that the cast extends above the trimline. If you want the posterior height to be other than the default standard (⅔ to ¾ of lower leg length), or to specify the exact height (recommended), write it in.

Toe Shelf—If you need to help contain forefoot adduction or abduction on our flexible toe shelf, choose the containment options: medial (to contain adduction) or lateral (to contain abduction). If the liner is polyethylene, the outer frame trimline ends at the sulcus; for a Softy liner, the outer frame trimline extends full-length under the plantar surface. If needed, you can fine-tune these trimlines on the order sheet.

Special Instructions—Write in any needed features or options not shown on the order form. Note anatomical irregularities, measurements that may help us create the brace, or requests for product information or other materials. To help us understand your needs, please attach photos or additional pages.

To rush your order, check the **Rush order** box in this section. Rushing an order adds $20 to the cost.

You can also download these forms at our website, ***www.cascadedafo.com/order-forms***.

- You can print and fill out the standard Adobe Acrobat PDF files.
- For the better clarity of a typed form, use the Adobe Acrobat eForms: fill out the order electronically, save the file with patient records and print it when done.
- For Fast Fit products (that won't be sent with a cast), you can fill an order form out, save, and email it to ***customersupport@dafo.com***. For best results, use Acrobat 5.0 (or later).

Thank you for ordering from us!

CASCADE® dafo®

If you have any questions, please ask our Customer Support staff (c*ustomersupport@dafo.com* 800-848-7332).

To see color and pattern choices for padding and straps, visit *www.cascadedafo.com/ordering/color-patterns* or call Customer Support at 800.848.7332 and ask for a free flipper (swatch set).

Fast Fit® Product Styles

Fast Fit Product Styles—Options

Here are illustrations of bracing options that differ visibly from the standard. To see what options are available for what brace, check the order form.

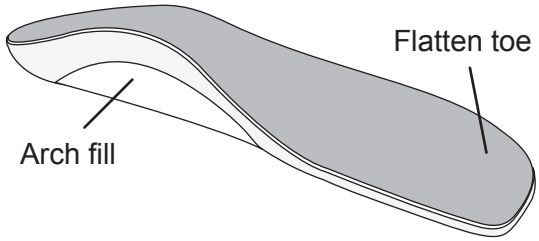


Figure A

Figure B

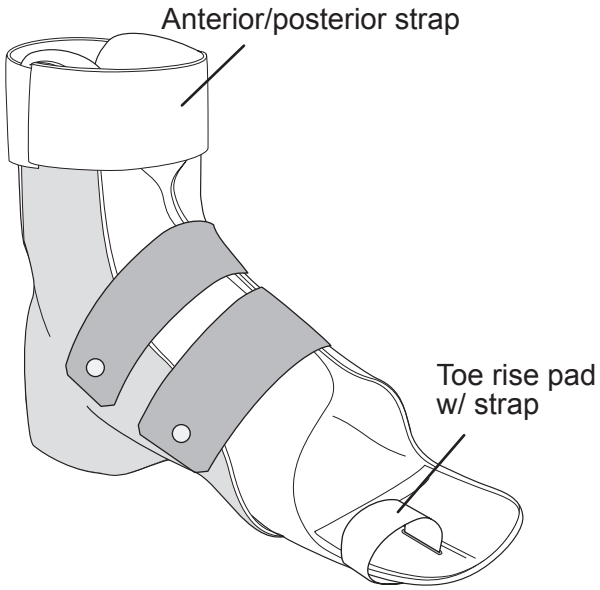


Figure C

Strap holds heel down through the use of an internal strap component.

Options Index

Option	Figure
Anterior/posterior strap	**C**
	A
Flatten toe rise	**A**
Instep pad	**B**
Super heel seating strap	**B**
Toe rise pad	**B**
Toe rise pad w/ strap	**C**

TO ORDER—1) SAVE to desktop 2) Fill this out 3) Print, fax/mail to Cascade; -or- fill this out, save, email to customersupport@dafo.com

Clear Form Data

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | intl +1 360 543 9306
fax 855.543.0092 | www.cascadedafo.com

HotDog®

Minimum support shoe insert

No Casting

Today's Date: _____

Patient

Last name:

First name: ☐ Male ☐ Female

Birth date:

Parent or Guardian:

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**

Account Name or #:

P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**

—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)

☐ Check attached

Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder's Phone:

Credit Card No:

Exact name on card:

Exp. Date: V-code:

Billing Information

Billing Name:

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Shipping

☐ **Same as billing information.** **–OR–**

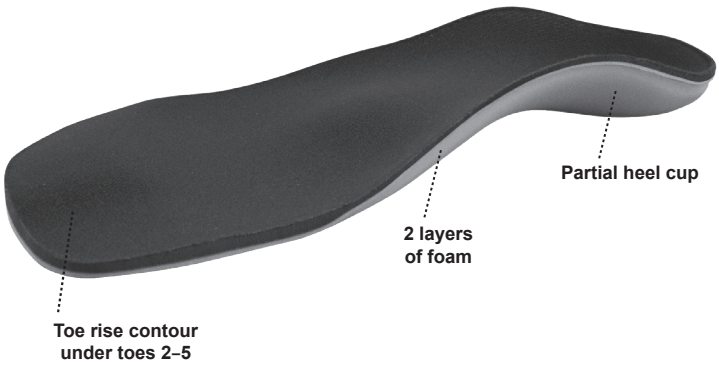
Shipping contact name:

Street address:

City: State: Zip:

Phone:

Size | Options



Sizing ☐ Pair ☐ Left ☐ Right

Length: _____ *3.00 – 12.25 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

Fill Arches? ☐ Soft Foam *(additional charge)*

-or-

☐ Medium Foam *(additional charge)*

Flatten Toe Rise? ☐ Yes

☐ No

Comments

Thank you!

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fax 855.543.0092 | www.cascadedafo.com

FAST FIT

PattiBob®

Moderate support shoe insert

No Casting

Today's Date: _____

Patient

Last name:

First name: ☐ Male ☐ Female

Birth date:

Parent or Guardian:

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**

Account Name or #:

P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**

—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)

☐ Check attached

Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder's Phone:

Credit Card No:

Exact name on card:

Exp. Date: V-code:

Billing Information

Billing Name:

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Shipping

☐ **Same as billing information.** **–OR–**

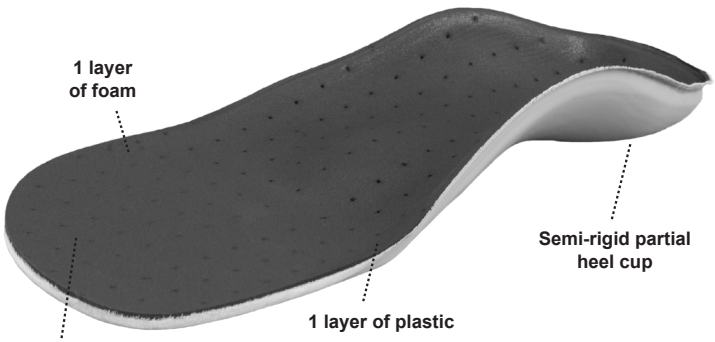
Shipping contact name:

Street address:

City: State: Zip:

Phone:

Size | Options



Sizing ☐ Pair ☐ Left ☐ Right

Length: _____ *3.00 – 12.25 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

Fill Arches? ☐ Soft Foam *(additional charge)* -or- ☐ Medium Foam *(additional charge)*

Flatten Toe Rise? ☐ Yes ☐ No

Comments

Thank you!

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fax 855.543.0092 | **www.cascadedafo.com**

FAST FIT

Bug

Moderate support shoe insert

No Casting

Today's Date: _____

Patient

Last name:
First name: ☐ Male ☐ Female
Birth date:
Parent or Guardian:

Practitioner

Name: **Title:**
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**
Account Name or #:
P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**
—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)
☐ Check attached
Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover
Cardholder's Phone:
Credit Card No:
Exact name on card:
Exp. Date: V-code:

Billing Information

Billing Name:
Facility:
Street address:
City: State: Zip:
Phone:
Email:

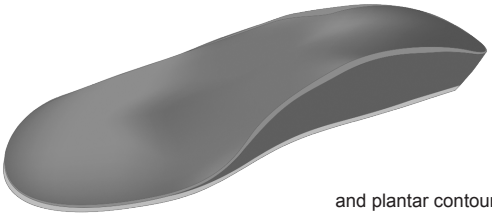
Shipping

☐ **Same as billing information.** **–OR–**
Shipping contact name:
Street address:
City: State: Zip:
Phone:

Size

High density foam construction

and partial heel cup



Built-in heel stabilization

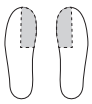
and plantar contours

Flattened toe shelf

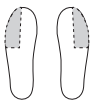
Sizing ☐ Pair ☐ Left ☐ Right Length: _____ *4.00 – 13.00 in. (0.25 in. increments)*

Options

Add Forefoot Posting? ☐ 1/8" ☐ 3/16" ☐ 1/4"



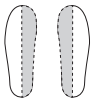
☐ Medial



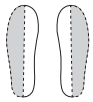
☐ Lateral

-or-

Add Medial or Lateral Wedge? ☐ 1/8" ☐ 3/16" ☐ 1/4"



☐ Medial



☐ Lateral

-or-

Add Wedge?

Heel-to-Met. Head Wedge ☐ 1/8" ☐ 3/16" ☐ 1/4"

Full Heel Wedge ☐ 1/8" ☐ 3/16" ☐ 1/4"

-or-

Add Lift?

☐ 1/8" ☐ 3/16" ☐ 1/4" ☐ 3/8"

Comments

Thank you!

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fax 855.543.0092 | **www.cascadedafo.com**

FAST FIT

Chipmunk®

Maximum support shoe insert

No Casting

Today's Date: _____

Patient

Last name:
First name: ☐ Male ☐ Female
Birth date:
Parent or Guardian:

Practitioner

Name: **Title:**
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**
Account Name or #:
P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**
—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)
☐ Check attached
Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover
Cardholder's Phone:
Credit Card No:
Exact name on card:
Exp. Date: V-code:

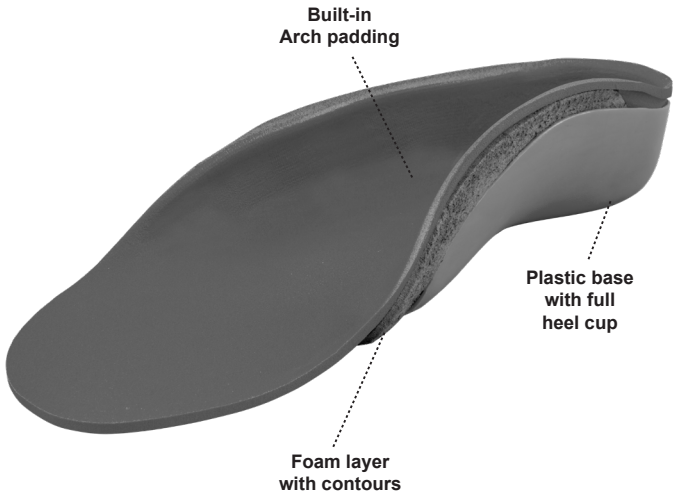
Billing Information

Billing Name:
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Shipping

☐ **Same as billing information.** **–OR–**
Shipping contact name:
Street address:
City: State: Zip:
Phone:

Size



Sizing ☐ Pair ☐ Left ☐ Right

Length: _____ *4.00 – 12.25 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

Comments

Thank you!

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fax 855.543.0092 | www.cascadedafo.com

FAST FIT

Cricket®

Sub-malleolar, UCBL trimline

No Casting

Today's Date: _____

Patient

Last name:

First name: ☐ Male ☐ Female

Birth date:

Parent or Guardian:

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**

Account Name or #:

P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**

—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)

☐ Check attached

Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder's Phone:

Credit Card No:

Exact name on card:

Exp. Date: V-code:

Billing Information

Billing Name:

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Shipping

☐ **Same as billing information.** **–OR–**

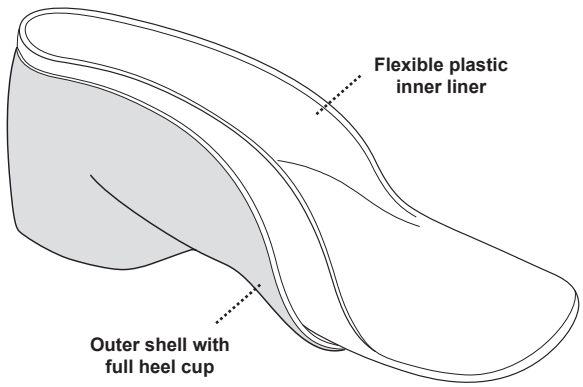
Shipping contact name:

Street address:

City: State: Zip:

Phone:

Size | Outer Shell | Options



1 Sizing

☐ Pair ☐ Left ☐ Right

Length: _____ *4.00 – 9.00 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

2 Outer Shell

☐ **Moderate Flexibility – Polyethylene**
Recommended for sizes 4.00 – 8.00 (available for all sizes)

Shell color: ☐ Blue ☐ Pink

-or-

☐ **Firm – Co-poly** *(shell color:* **White only***)*
Recommended for sizes 8.25 – 9.00 (available for all sizes)

3 Options

☐ Toe rise pad

☐ Toe rise pad with abduction strap

Comments

Thank you!

TO ORDER—fill this out, print, fax/mail to Cascade; -or- fill this out, save, email to customerservice@dafo.com

Clear Form Data

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fax 855.543.0092 | **www.cascadedafo.com**

FAST FIT

JumpStart® LeapFrog®

PF free, DF free, SMO trimline

No Casting

Today's Date: _____

Patient

Last name:
First name: ☐ Male ☐ Female
Birth date:
Parent or Guardian:

Practitioner

Name: **Title:**
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**
Account Name or #:
P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**
—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)
☐ Check attached
Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover
Cardholder's Phone:
Credit Card No:
Exact name on card:
Exp. Date: V-code:

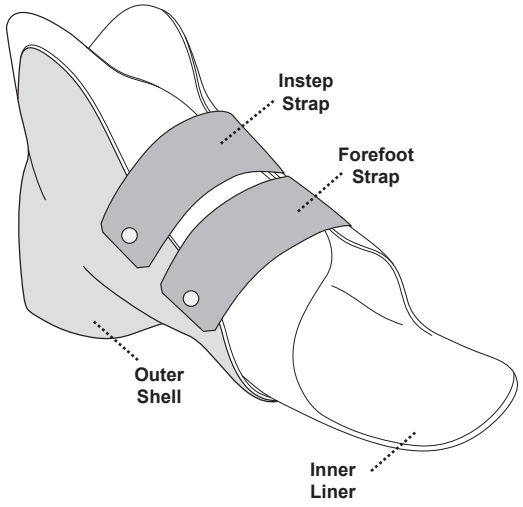
Billing Information

Billing Name:
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Shipping

☐ **Same as billing information.** **–OR–**
Shipping contact name:
Street address:
City: State: Zip:
Phone:

Size | Outer Shell | Straps | Options



1 Sizing ☐ Pair ☐ Left ☐ Right

Length: _____ *4.00 – 9.00 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

2 Outer Shell

☐ **Moderate Flexibility – Polyethylene**
Recommended for sizes 4.00 – 8.00 (available for all sizes)
Shell color: ☐ Blue ☐ Pink

-or-

☐ **Firm – Co-poly** *(shell color:* **White only***)*
Recommended for sizes 8.25 – 9.00 (available for all sizes)

3 Straps

Color: ☐ Blue ☐ Pink

Instep: *choose one*
☐ Riveted layover
☐ Layover *(no rivets)*
☐ Riveted D-ring

Forefoot: *choose one*
☐ Riveted Layover
☐ Layover *(no rivets)*

4 Options
☐ Instep pad
☐ Toe rise pad
☐ Toe rise pad with abduction strap

Comments

Thank you!

TO ORDER—fill this out, print, fax/mail to Cascade; -or- fill this out, save, email to customerservice@dafo.com

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fax 855.543.0092 | **www.cascadedafo.com**

FAST FIT

JumpStart® Bunny®

High SMO with proximal strap, PF resist, optional DF resist

No Casting

Today's Date: _____

Patient

Last name:
First name: ☐ Male ☐ Female
Birth date:
Parent or Guardian:

Practitioner

Name: **Title:**
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**
Account Name or #:
P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**
—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)
☐ Check attached
Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover
Cardholder's Phone:
Credit Card No:
Exact name on card:
Exp. Date: V-code:

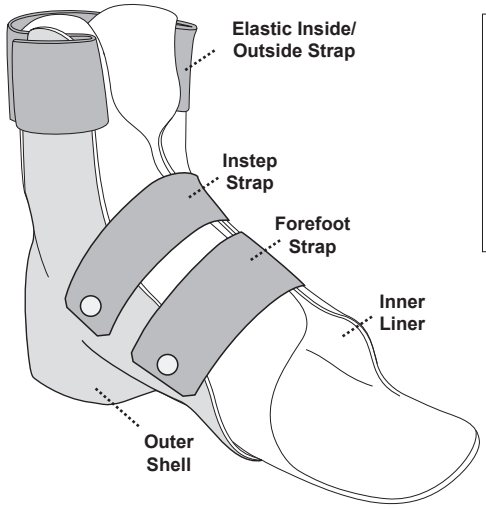
Billing Information

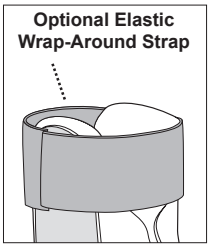
Billing Name:
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Shipping

☐ **Same as billing information.** **–OR–**
Shipping contact name:
Street address:
City: State: Zip:
Phone:

Size | Outer Shell | Straps | Options





1 Sizing ☐ Pair ☐ Left ☐ Right

Length: _____ *4.00 – 9.00 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

2 Outer Shell

☐ **Moderate Flexibility – Polyethylene**
Recommended for sizes 4.00 – 5.75 (available for all sizes)
Shell color: ☐ Blue ☐ Pink

-or-

☐ **Firm – Co-poly** *(shell color:* **White only***)*
Recommended for sizes 6.00 – 9.00 (available for all sizes)

3 Straps

Color: ☐ Blue ☐ Pink

Posterior: *choose one*
☐ Elastic Inside / Outside *(resists PF)*
☐ Elastic Wrap-Around *(resists PF and DF)*

Instep: *choose one*
☐ Riveted layover
☐ Layover (no rivets)
☐ Riveted D-ring

Forefoot: *choose one*
☐ Riveted Layover
☐ Layover (no rivets)

4 Options
☐ Instep pad
☐ Toe rise pad
☐ Toe rise pad with abduction strap

Comments

Thank you!

TO ORDER—fill this out, print, fax/mail to Cascade; -or- fill this out, save, email to customerservice@dafo.com

Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | intl +1 360 543 9306
fax 855.543.0092 | www.cascadedafo.com

FAST FIT

JumpStart® SoftBack

PF resist, DF free

No Casting

Today's Date: _____

Patient

Last name:

First name: ☐ Male ☐ Female

Birth date:

Parent or Guardian:

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**

Account Name or #:

P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**

—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)

☐ Check attached

Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder's Phone:

Credit Card No:

Exact name on card:

Exp. Date: V-code:

Billing Information

Billing Name:

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Shipping

☐ **Same as billing information.** **–OR–**

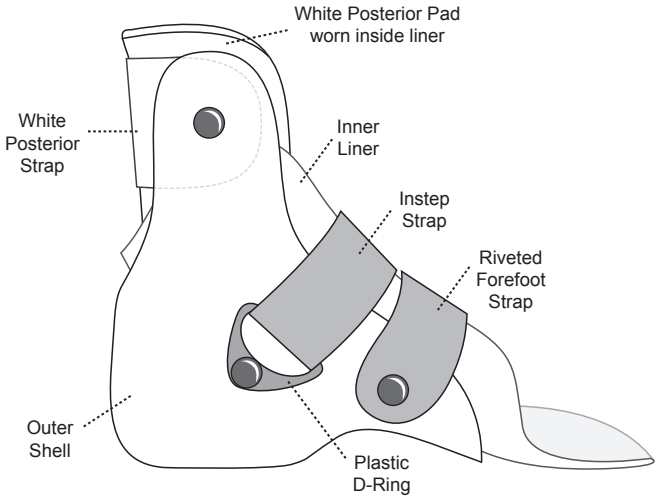
Shipping contact name:

Street address:

City: State: Zip:

Phone:

Size | Outer Shell | Straps | Options



1 Sizing

☐ Pair ☐ Left ☐ Right

Length: _____ *4.00 – 9.00 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

2 Outer Shell

☐ **Firm – Co-poly (Standard)**
(shell color: **White only***)*

☐ Moderate Flexibility – Polyethylene

Shell color: ☐ Blue ☐ Pink

3 Straps Color

☐ Blue ☐ Pink

NOTE: The posterior strap color is available in white dacron only.

4 Options

☐ Instep pad

☐ Toe rise pad

☐ Toe rise pad with abduction strap

Comments

Thank you!

TO ORDER—fill this out, print, fax/mail to Cascade; -or- fill this out, save, email to customerservice@dafo.com

Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | intl +1 360 543 9306
fax 855.543.0092 | www.cascadedafo.com

FAST FIT

JumpStart® Kangaroo®

PF block, DF free, AFO trimline

No Casting

Today's Date: _____

Patient

Last name:

First name: ☐ Male ☐ Female

Birth date:

Parent or Guardian:

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Payment Options

☐ **Facility Billing** (Practitioner) **–OR–**

Account Name or #:

P.O. Nº : ☐

☐ **Insurance Billing** (Parent / Guardian / Practitioner) **–OR–**

—UCAN Nº :

☐ **Direct Purchase** (Parent / Guardian)

☐ Check attached

Credit Card: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder's Phone:

Credit Card No:

Exact name on card:

Exp. Date: V-code:

Billing Information

Billing Name:

Facility:

Street address:

City: State: Zip:

Phone:

Email:

Shipping

☐ **Same as billing information.** **–OR–**

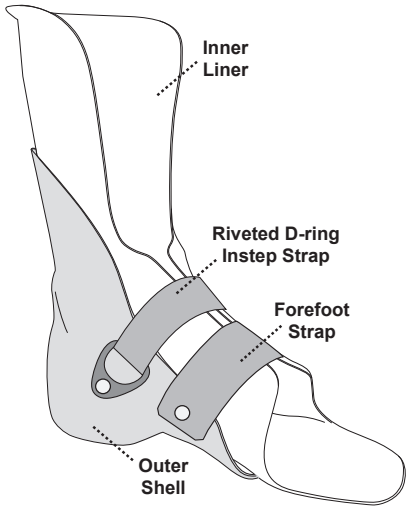
Shipping contact name:

Street address:

City: State: Zip:

Phone:

Size | Outer Shell | Straps | Options



1 Sizing ☐ Pair ☐ Left ☐ Right

Length: _____ *4.00 – 9.00 in. (0.25 in. increments)*

Width: ☐ Wide ☐ Narrow

2 Inner Liner *choose one*

☐ **Regular** *height is same as foot length (ideal for ambulation)*

☐ **Tall** *height is 20% taller than foot length (ideal for night splints)*

3 Outer Shell

☐ **Moderate Flexibility – Polyethylene**
Recommended for sizes 4.00 – 8.00 (available for all sizes)

Shell color: ☐ Blue ☐ Pink

-or-

☐ **Firm – Co-poly** *(shell color:* **White only***)*
Recommended for sizes 8.25 – 9.00 (available for all sizes)

4 Straps

Color: ☐ Blue ☐ Pink

Instep: *choose one*

☐ Riveted layover
☐ Layover (no rivets)
☐ Riveted D-ring
☐ Super Heel Seating (for excessive PF control)

Forefoot: *choose one*

☐ Riveted Layover
☐ Layover (no rivets)

5 Options

☐ Instep pad
☐ Toe rise pad
☐ Toe rise pad with abduction strap

Comments

Thank you!

TO ORDER—1) SAVE to desktop 2) Fill this out 3) Print, fax/mail to Cascade; -or- fill this out, save, email to customersupport@dafo.com

Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

JIA Shoe Inserts

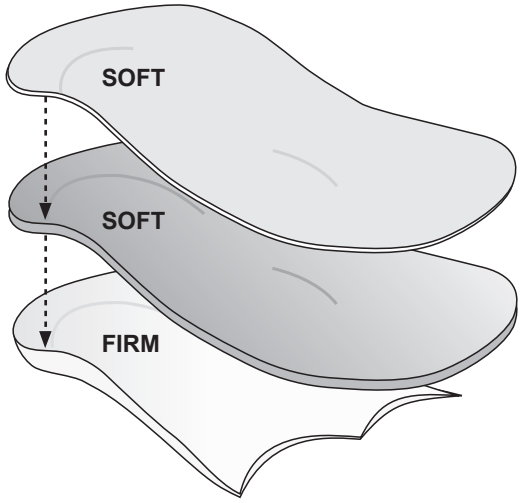
No Casting

Patient

Patient name:	Parent / Guardian name:

Product

Qty	Foot	Length *(size)*	Width	Fill Arches?
	☐ PAIR ☐ Left ☐ Right		☐ Narrow ☐ Wide	☐ Soft foam **Recommended** ☐ Medium foam



- Super-soft foam for maximum comfort.
- Excellent pressure relief along metatarsal heads.
- Firmer support for hindfoot.
- For sizing, use the Cascade Fast Fit™ sizing jig.

Special Instructions

Payment Options

☐ **Facility Billing** (Practitioner)	Account Name / #:	PO #:	☐ C.C. On File

OR

☐ **Insurance Billing** (Parent / Guardian / Practitioner)	UCAN N°:	Phone:

OR

☐ **Direct Purchase** (Parent / Guardian)	☐ Check Attached	Credit card: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover	Cardholder's phone:

Credit Card N°:	Exact name on card:	Exp. Date:	V-Code:

For current product pricing & shipping costs, please call our Customer Support staff at: 800-848-7332.

Billing

Name:
Facility:
Street address:
City: State: Zip:
Phone:
Email:

Shipping

☐ **Same as Billing Information**
Shipping contact name:
Street address:
City: State: Zip:
Phone:
Email:

Thank you!

DAFO® Product Styles

DAFO® Product Styles—Options

Here are illustrations of bracing options that differ visibly from the standard. To see what options are available for what brace, check the order form.

Other optimizations are available. For more information, call Customer Support at **800-848-7332**.

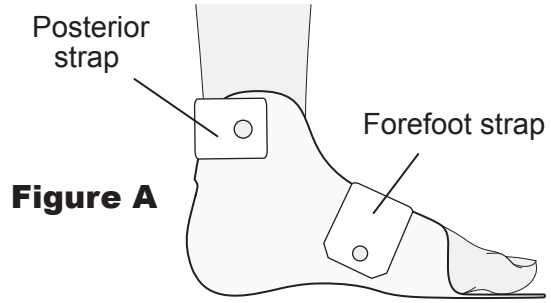


Figure A

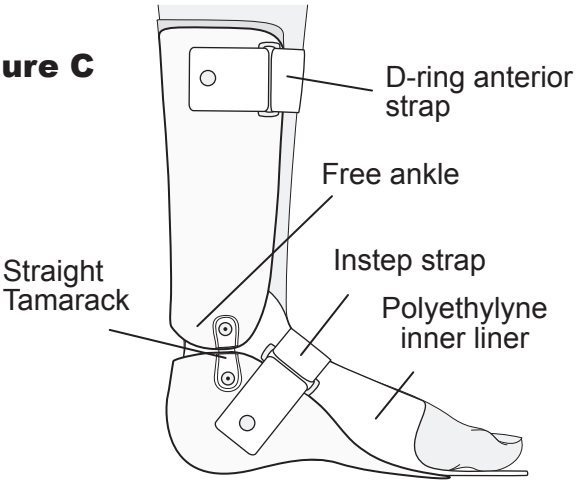


Figure C

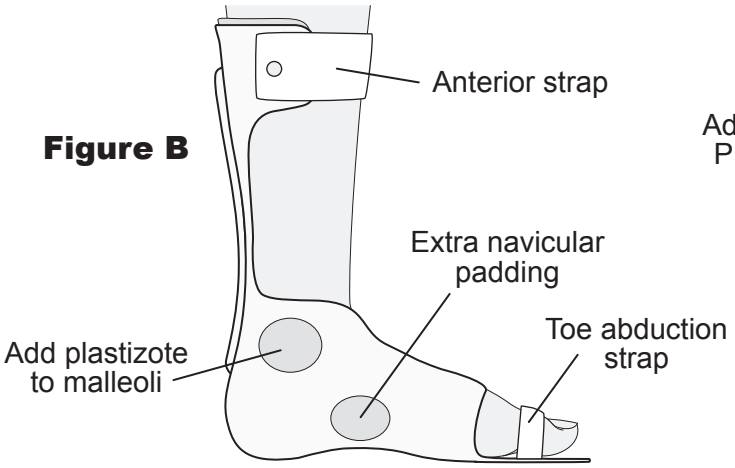


Figure B

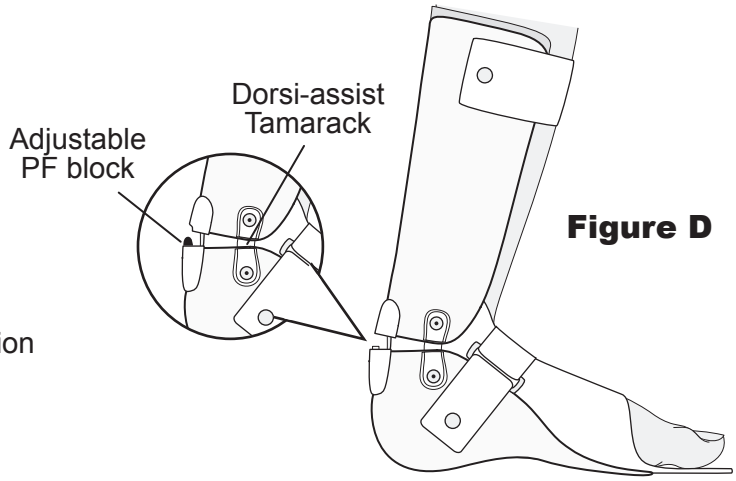


Figure D

Options Index

Option	Figure
Add plastizote to malleoli	**B**
Anterior strap	**B**
D-ring anterior strap	**C**
Extra navicular padding	**B**
Forefoot strap	**A**
Instep strap	**C**
Polyethylene inner liner	**C**

Option	Figure
Posterior strap	**A**
Toe abduction strap	**B**

Tami2 Option	Figure
Adjustable PF block	**D (inset)**
Dorsi-assist Tamarack	**D**
Free ankle	**C**
Straight Tamarack	**C**

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 2

Hinged PF block, DF free

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

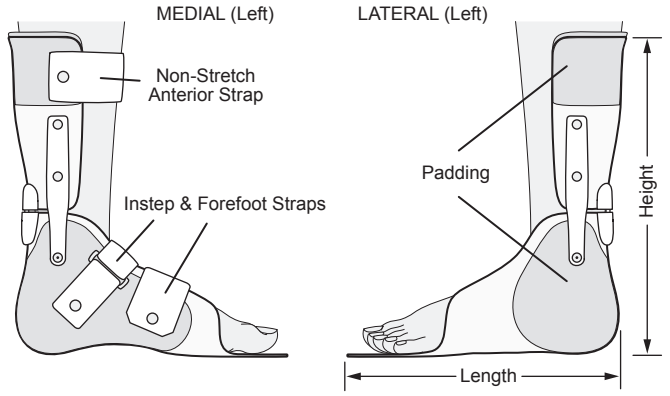
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

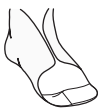
Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO 2 Softy

Hinged PF block, DF free, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

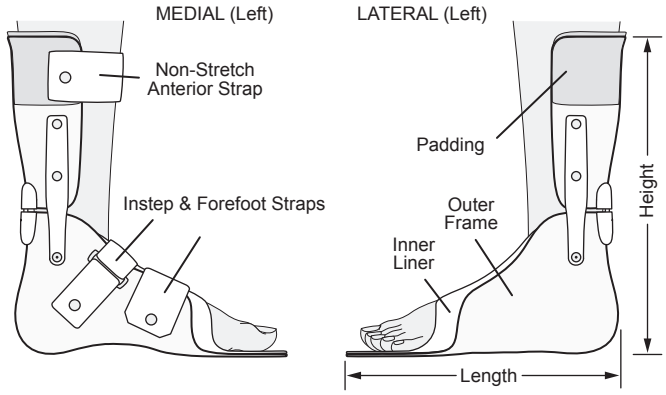
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Inner Liner: ☐ **Softy foam** (white only) **Standard** (outer frame extends to full-length) ☐ Polyethylene (outer frame trimmed at sulcus)

☐ Add extra navicular padding (boney pronators only)

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf—Inner Liner

☐ **Flexible — no containment Standard**

☐ Medial containment:

AND / OR

☐ Lateral containment:

Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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CASCADE dafo

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1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 3

PF block, DF free

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

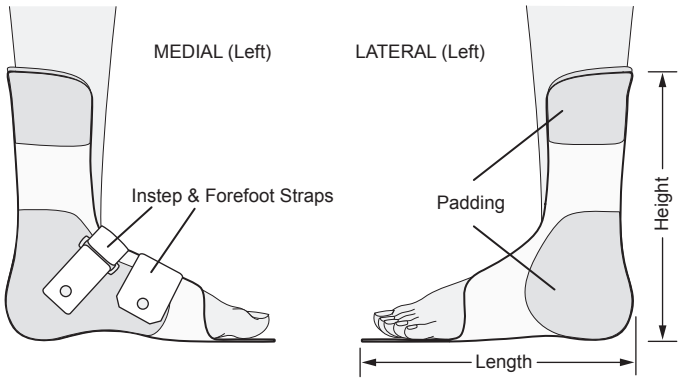
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **Height = foot length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

(NOTE: The DAFO 3 is not designed to block DF. If DF block is needed, see the DAFO FA or Turbo.)

Strap Color: ☐ **White Standard** ☐ Other: _____

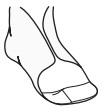
Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO 3 Softy

PF block, DF free, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

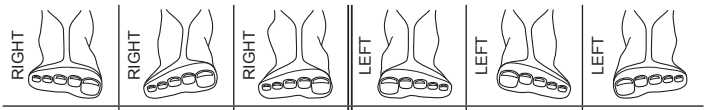
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

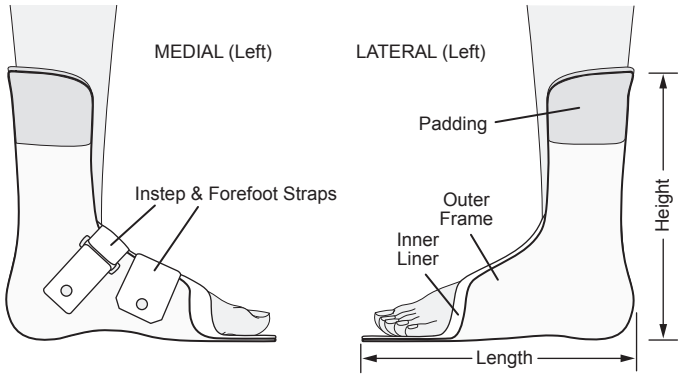
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **Height = foot length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Inner Liner: ☐ **Softy foam** (white only) **Standard** (outer frame extends to full-length) ☐ Polyethylene (outer frame trimmed at sulcus)

☐ Add extra navicular padding (boney pronators only)

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

(NOTE: The DAFO 3 is not designed to block DF. If DF block is needed, see the DAFO FA or Turbo.)

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

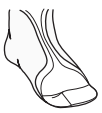
(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf—Inner Liner

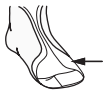
☐ **Flexible — no containment Standard**



☐ Medial containment:

AND / OR

☐ Lateral containment:



Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 3.5

PF resist, DF resist

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

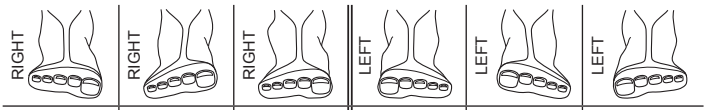
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

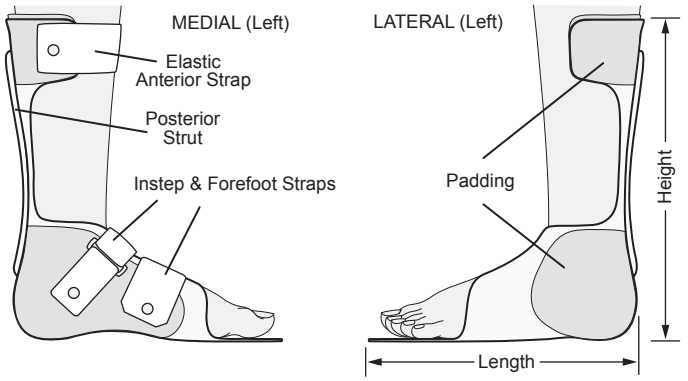
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ ⅔ to ¾ of leg length **Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Posterior Strut: ☐ V ☐ **Standard** ☐ Semi-rigid

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Add toe abduction strap ☐ Change anterior strap to non-stretch

Strap Color: ☐ **White Standard** ☐ Other: _____

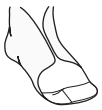
Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

☐ **Rush order** (adds $20)

Thank you!

TO ORDER— 1) SAVE to desktop 2) Fill in eForm 3) Print and send with the patient's cast to Cascade

Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 3.5 Softy®

PF resist, DF resist, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

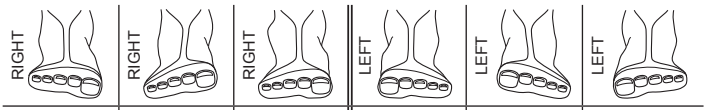
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

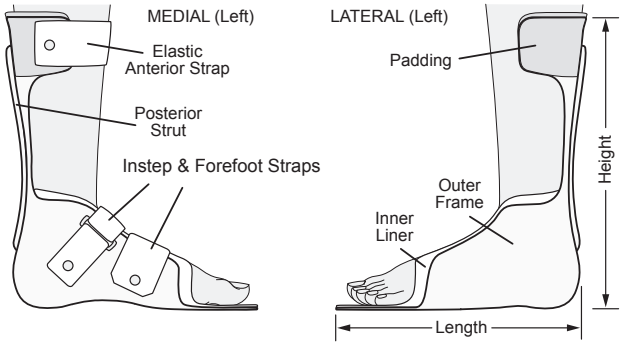
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Posterior Strut: ☐ V ☐ **Standard** ☐ Semi-rigid

Inner Liner: ☐ **Softy foam** (white only) **Standard** (outer frame extends to full-length) ☐ Polyethylene (outer frame trimmed at sulcus)

☐ Add extra navicular padding (boney pronators only)

Straps: **Standard** (see drawing) ☐ Add toe abduction strap ☐ Change anterior strap to non-stretch

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

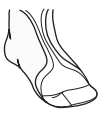
(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf—Inner Liner

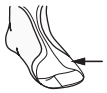
☐ **Flexible — no containment Standard**



☐ Medial containment:

AND / OR

☐ Lateral containment:



Special Instructions

☐ **Rush order** (adds $20)

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 4

PF free, DF free

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

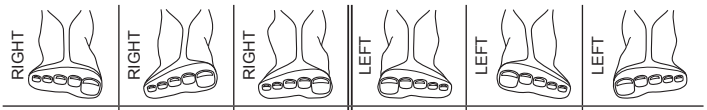
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

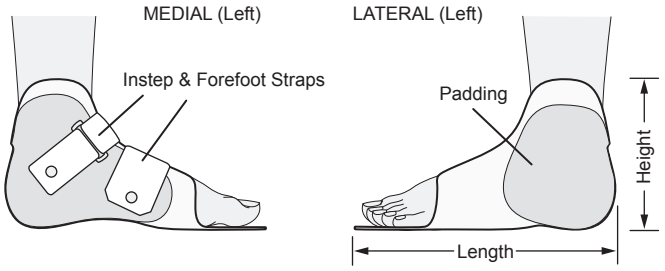
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Height: ☐ Above malleoli **Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Add Anterior Strap: ☐ Non-stretch **- or -** ☐ Elastic

Add Posterior Strap: ☐ Non-stretch **- or -** ☐ Elastic

straps will increase height

Strap Color: ☐ **White Standard** ☐ Other: _____

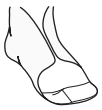
Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

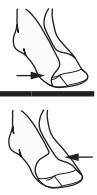
☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic



Special Instructions

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO 4 Softy

PF free, DF free, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

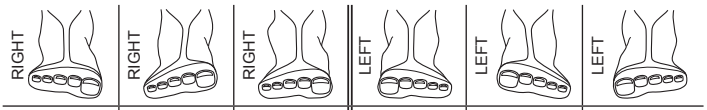
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

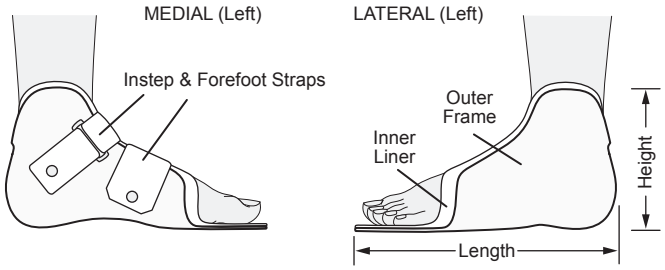
NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

☐ Entire bottom stabilized with foam sole

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

☐ Entire bottom stabilized with foam sole and non-skid cover

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Height: ☐ Above malleoli **Standard** ☐ Specify: ____

• Cast height must be greater than brace height •

Inner Liner: ☐ **Softy foam** (white only) **Standard** (outer frame extends to full-length) ☐ Polyethylene (outer frame trimmed at sulcus)

☐ Add extra navicular padding (boney pronators only)

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Add Anterior Strap: ☐ Non-stretch **- or -** ☐ Elastic

Add Posterior Strap: ☐ Non-stretch **- or -** ☐ Elastic

straps will increase height

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

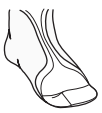
(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise Pad Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf—Inner Liner

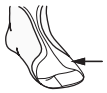
☐ **Flexible — no containment Standard**



☐ Medial containment:

AND / OR

☐ Lateral containment:



Special Instructions

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Thank you!

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Clear Form Data

CASCADE dafo

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 5

Maximum control foot orthosis

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN Nº:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. Nº:

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

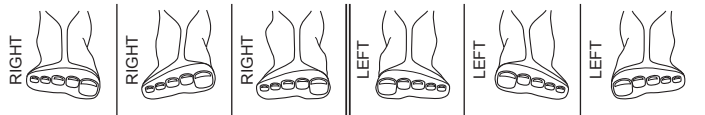
Finished Brace Angles

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct (Cast alignment OK)

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ Midfoot & Medial Heel—**Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

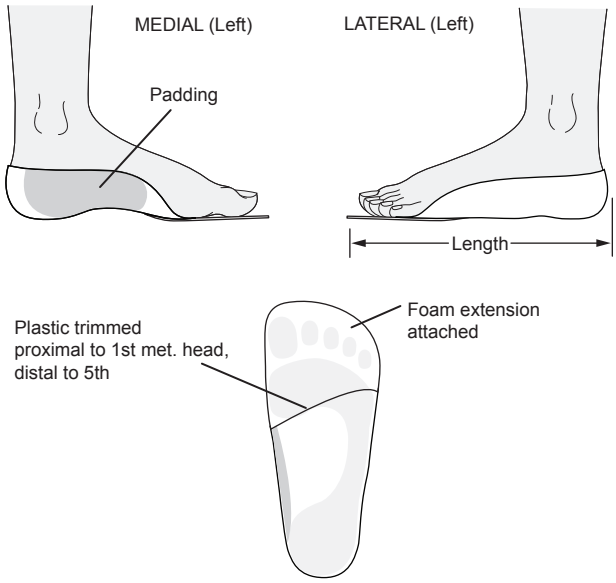
☐ Entire bottom stabilized with foam sole

☐ None

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Outer Frame: ☐ **Co-Poly Standard** ☐ Polyethylene *(Transfer Pattern is not an option)*

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

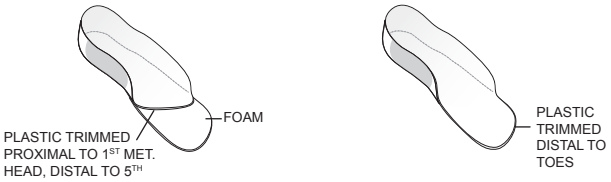
Padding Color: ☐ **White Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Very Flexible Standard** ☐ Full length plastic



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DAFO 5 Softy

Maximum control foot orthosis, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

☐ Midfoot & Medial Heel—**Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

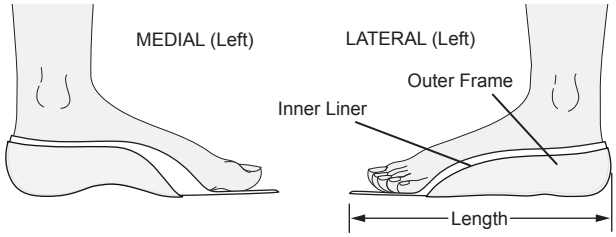
☐ Entire bottom stabilized with foam sole

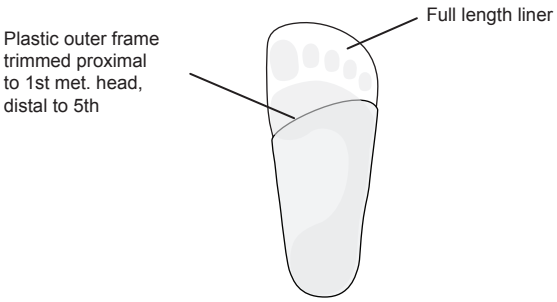
☐ None

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options





NOTE: If you don't choose an option, you will receive the Standard.

Outer Frame: ☐ **Co-Poly Standard** ☐ Polyethylene *(Transfer Pattern is not an option)*

Inner Liner: ☐ **Softy foam** (white only) **Standard** ☐ Polyethylene

☐ Add extra navicular padding (boney pronators only)

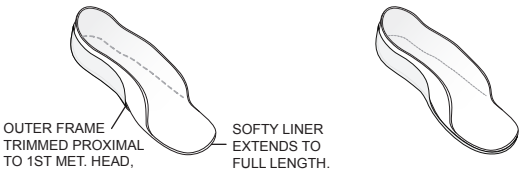
Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf

☐ Liner only full length **Standard** ☐ Plastic outer frame and liner full length



Special Instructions

☐ **Rush order** (adds $20)

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DAFO® 8

Resting, non-ambulatory

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

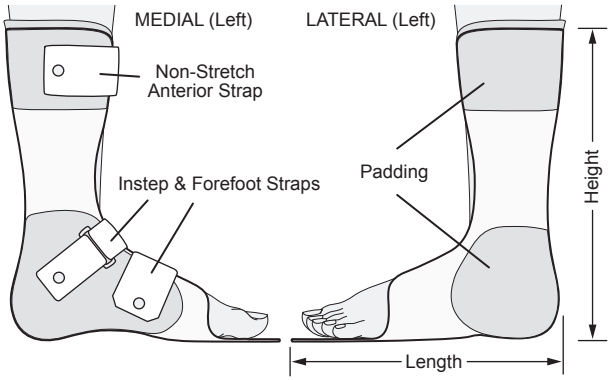
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

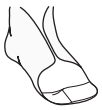
Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Toe Shelf

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

☐ **Rush order** (adds $20)

Thank you!

TO ORDER— 1) SAVE to desktop 2) Fill in eForm 3) Print and send with the patient's cast to Cascade

Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO 8 Softy

Resting, non-ambulatory, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

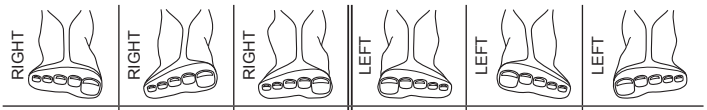
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

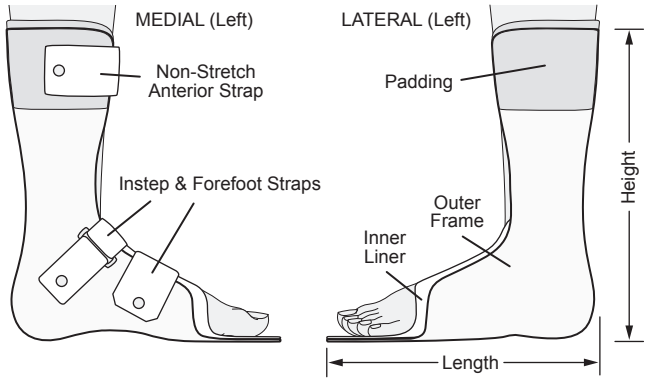
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Inner Liner: ☐ **Softy foam** (white only) **Standard** (outer frame extends to full-length) ☐ Polyethylene (outer frame trimmed at sulcus)

☐ Add extra navicular padding (boney pronators only)

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

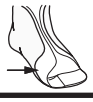
Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

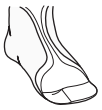
Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf—Inner Liner

☐ **Flexible — no containment Standard**

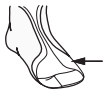
☐ **Medial containment:**





AND / OR

☐ **Lateral containment:**



Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 9 Softy®

Adjustable night-stretching brace

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

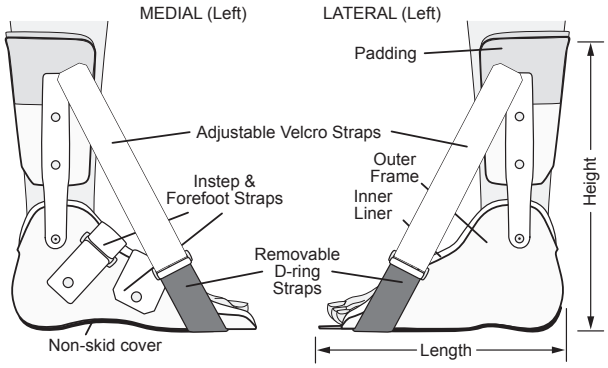
RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

Bottom covered with non-skid cover—**Standard**

NOTE—
Unless requested otherwise, varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

Outer Frame: ☐ **Polyethylene** ☐ **Co-poly** ☐ Polypro
(**Standard** to 8" foot length) (**Standard** above 8" foot length)
(Transfer Pattern is not an option on polyethylene)

Inner Liner: ☐ **Softy foam Standard** (white only) ☐ Polyethylene

☐ Add extra navicular padding

Straps: ☐ **Elastic removable d-ring strap Standard**
☐ Non-stretch removable d-ring strap
☐ Non-stretch d-ring strap riveted to medial/lateral sides
Select one

☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

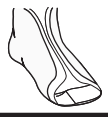
Instep Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**
(Outer frame only; additional cost per brace)
☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf—Inner Liner

Medial/Lateral soft containment—**Standard**



Special Instructions

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® FA

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

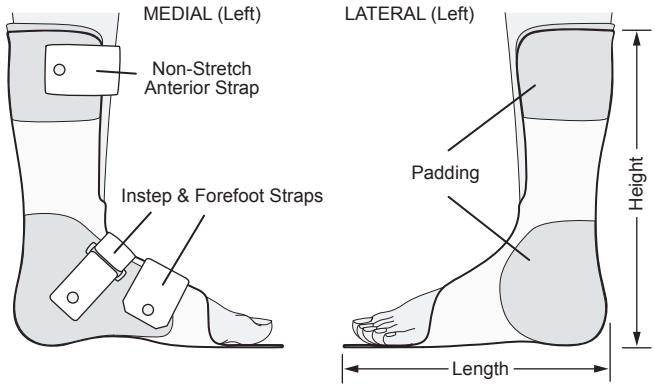
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

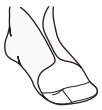
Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

☐ **Rush order** (adds $20)

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1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO FA Softy

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

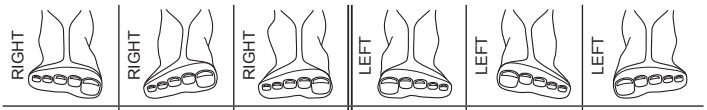
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

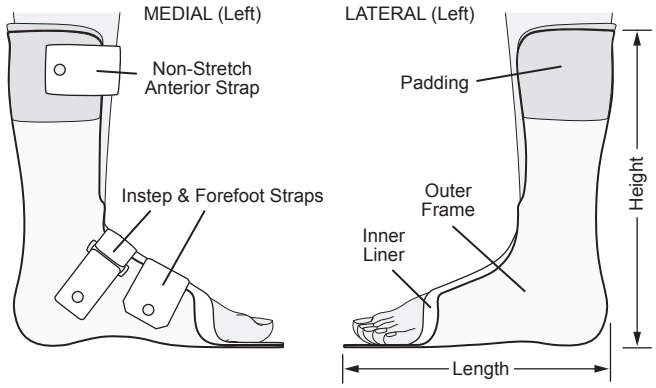
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ ⅔ to ¾ of leg length **Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Inner Liner: ☐ **Softy foam** (white only) **Standard** (outer frame extends to full-length) ☐ Polyethylene (outer frame trimmed at sulcus)

☐ Add extra navicular padding (boney pronators only)

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

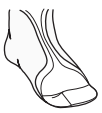
(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

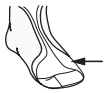
Toe Shelf—Inner Liner

☐ **Flexible — no containment Standard**



☐ Medial containment:

☐ Lateral containment:



Special Instructions

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Thank you!

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO FlexiSport

Strong PF resist, DF resist

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

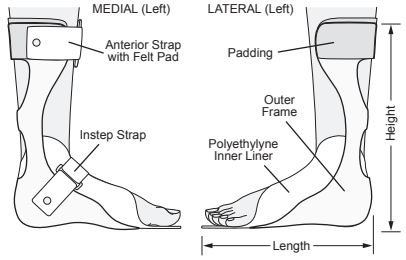
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ ⅔ to ¾ of leg length **Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Posterior Strut: ☐ **Standard** ☐ Semi-rigid

Inner Liner: ☐ **Polyethylene Standard** ☐ Softy foam (white only)

☐ Add extra navicular padding (boney pronators only) ☐ Add plastizote to malleoli

Straps: **Standard** (see drawing)

☐ Add D-ring to anterior strap

☐ Add forefoot strap

☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf

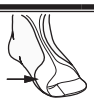
Outer Frame:

☐ Full-length under plantar surface (for mild crouching)

☐ Trimmed at sulcus under plantar surface

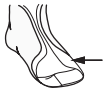
☐ **Flexible — no containment Standard**

☐ Medial containment:



AND / OR

☐ Lateral containment:



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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® Floor Reaction

Rear entry, DF block

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

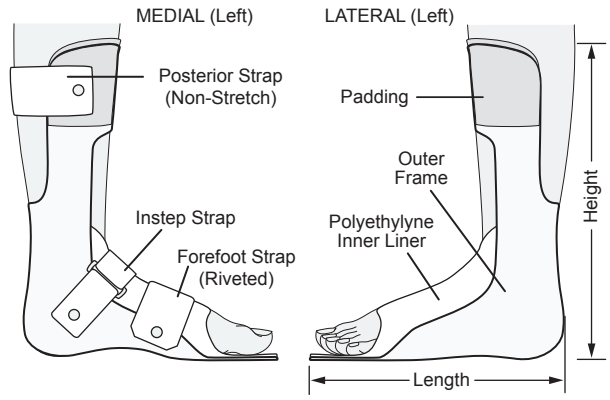
☐ **None—Standard**

☐ Heel

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options

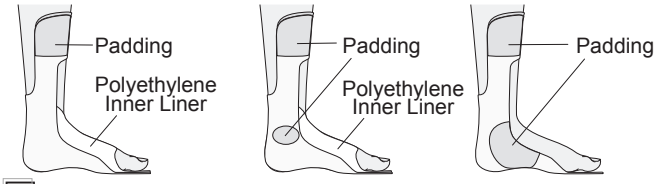


NOTE: If you don't choose an option, you will receive the Standard.

Anterior Height: ☐ **¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

☐ Option 1 **Standard** ☐ Option 2 ☐ Option 3 (No Liner)



☐ Add navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing)

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

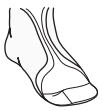
Transfer Pattern: ☐ **No Transfer Standard**

(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Inner Liner:

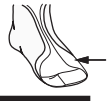
☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic



Special Instructions

☐ **Rush order** (adds $20)

Thank you!

TO ORDER— 1) SAVE to desktop 2) Fill in eForm 3) Print and send with the patient's cast to Cascade

Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® Softback™

PF resist, DF free

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

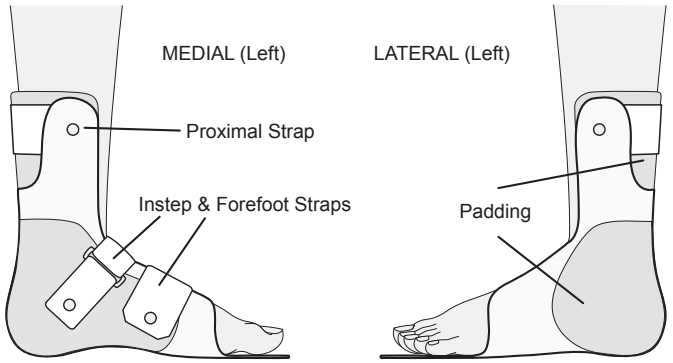
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

NOTE: The proximal padding color is available in white only.

Straps: **Standard** (see drawing)

☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

NOTE: The posterior strap color is available in white dacron only.

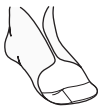
Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO Softback™ Softy®

PF resist, DF free, Softy liner

Patient

Last name:
First: ☐ Male ☐ Female
Date cast: ☐ **N** ☐ **W**
Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**
Facility:
Street address:
City: State: Zip:
Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**
—UCAN N°:
☐ **Billing info is the same as practitioner facility.** **–OR–**
☐ Billing facility:
Street address:
City: State: Zip:
P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**
Shipping contact name:
Street address:
City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**
Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

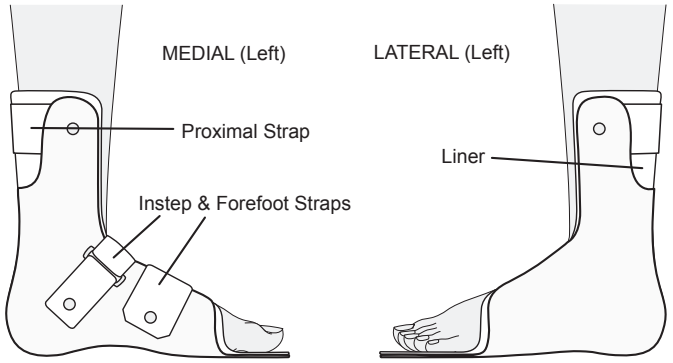
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Liner: **Softy foam** (white only) **Standard**
☐ Add extra navicular padding (boney pronators only)

Instep & Forefoot Straps: **Standard** (see drawing)
☐ Add toe abduction strap

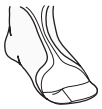
Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**
☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf—Inner Liner

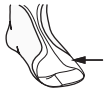
☐ **Flexible — no containment Standard**



☐ Medial containment:

AND / OR

☐ Lateral containment:



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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® Tami2

Hinged PF block, DF free

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

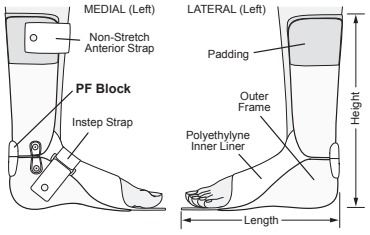
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Hinge Type: ☐ **Dorsi-assist Tamarack Standard**

Durometer (95 is stiffest):

☐ **75 d Standard** ☐ 85 d ☐ 95 d

☐ Straight Tamarack

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Inner Liner: ☐ **Polyethylene Standard** ☐ Softy foam (white only) ☐ None

☐ Add extra navicular padding (boney pronators only) ☐ Add plastizote to malleoli

Straps: **Standard** (tibial & instep straps) ☐ Add toe abduction strap ☐ Add forefoot strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf

Outer Frame:

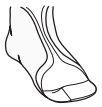
☐ Full-length under plantar surface

☐ Trimmed distal to met. heads under plantar surface

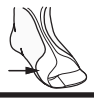
☐ Trimmed just proximal to met. heads under plantar surface

Inner Liner:

☐ **Flexible — no containment Standard**

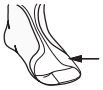


☐ Medial containment:



AND / OR

☐ Lateral containment:



Special Instructions

☐ **Rush order** (adds $20)

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® Turbo

PF block, DF block

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ _____	☐ _____	☐	☐	☐ _____	☐ _____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

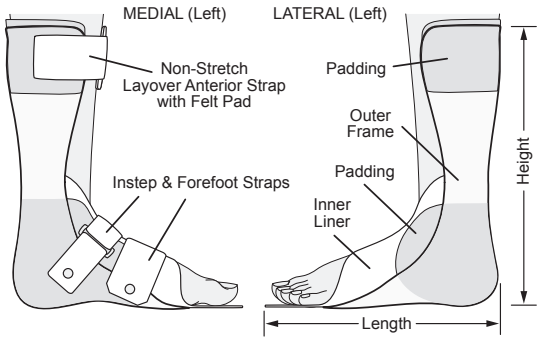
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Add toe abduction strap ☐ Add D-ring/pad to anterior strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

(Outer frame only; additional cost per brace)

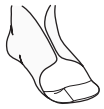
☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

Outer Frame: ☐ Full-length under plantar surface (for crouching) ☐ **Standard Trimmed at distal to met. heads under plantar surface** ☐ Trimmed just proximal to met. heads under plantar surface

Inner Liner:

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

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DAFO Turbo Softy

PF block, DF block, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

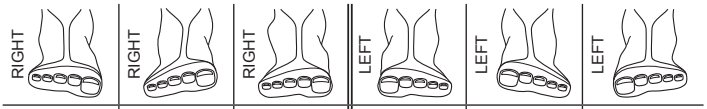
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

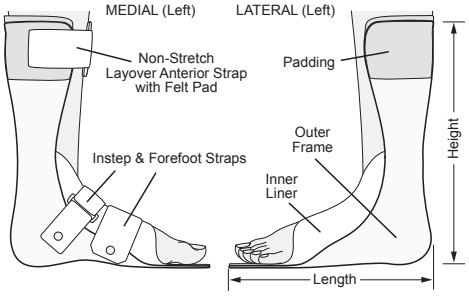
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Liner: ☐ **Softy foam (white only) Standard** (Full length toe shelf only) ☐ Polyethylene

☐ Add extra navicular padding (boney pronators only)

☐ Add plastizote to malleoli (recommended w. PE liner)

Straps: **Standard** (see drawing)

☐ Add D-ring/pad to ant. strap

☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf

Outer Frame:

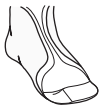
☐ Full-length under plantar surface (for crouching)

☐ Trimmed distal to met. heads under plantar surface

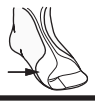
☐ Trimmed just proximal to met. heads under plantar surface

Inner Liner:

☐ **Flexible — no containment Standard**

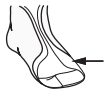


☐ Medial containment:



AND / OR

☐ Lateral containment:



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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® TwoStep

PF resist, DF free

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____ ° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus ☐ ____	Varus ☐ ____	Neutral ☐	Neutral ☐	Varus ☐ ____	Valgus ☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

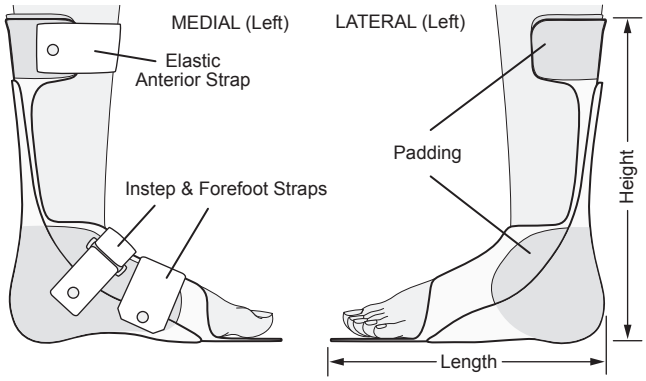
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Flexible — no containment Standard**

Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

☐ **Rush order** (adds $20)

Thank you!

Other Items

More Solutions—Product Options

Here are illustrations of bracing options that differ visibly from the standard. To see what options are available for what brace, check the order form.

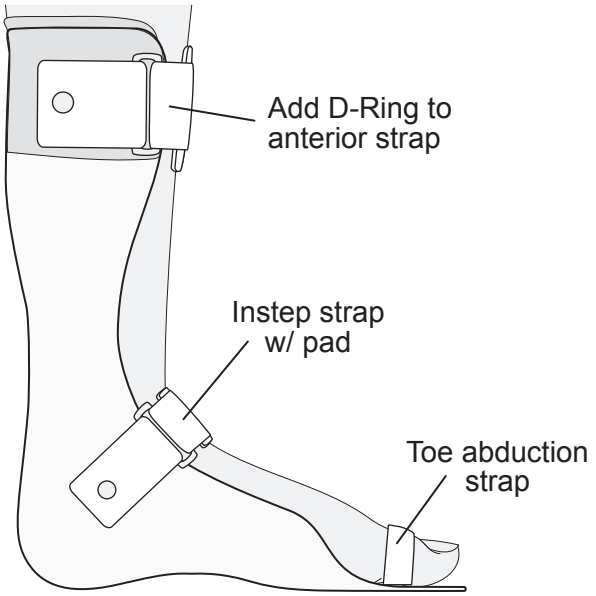


Figure A

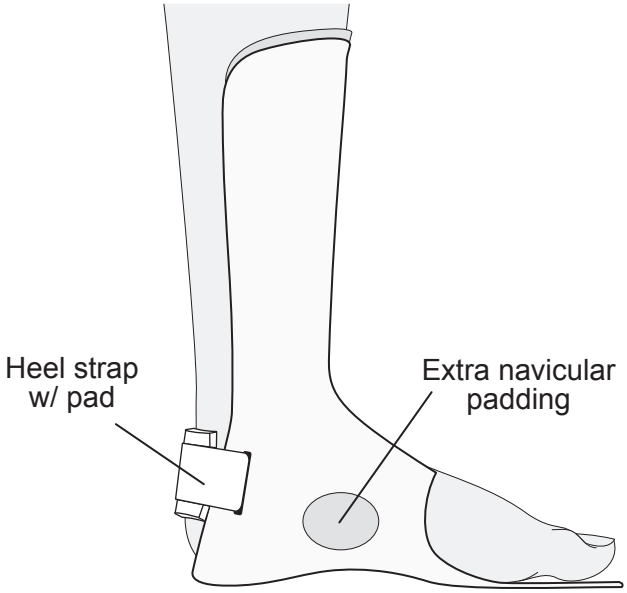


Figure C

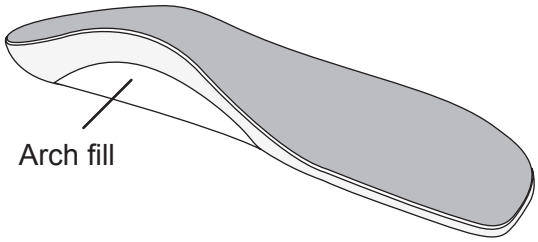


Figure B

Options Index

Option	Figure
Add D-ring to anterior strap	**A**
	B
Extra navicular padding	**C**
Instep strap w/ pad	**A**
Toe abduction strap	**A**

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Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 4.5

PF resist, DF assist, no dorsal wrap

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

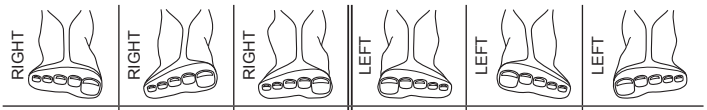
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

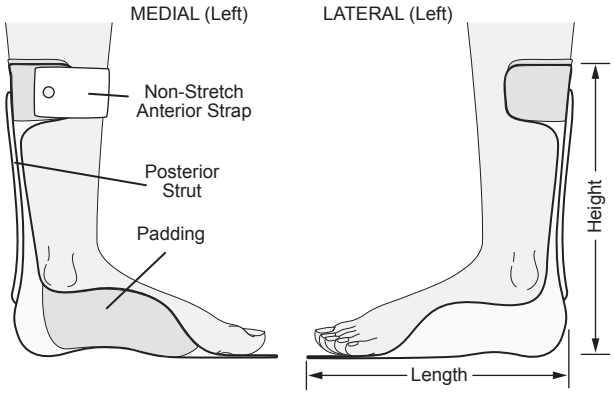
☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

☐ Entire bottom stabilized with foam sole

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Posterior Strut: ☐ Very ☐ **Standard** ☐ Semi-rigid

Padding: Shaded areas above are **Standard**

☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: ☐ **Standard** (see drawing) ☐ Change anterior strap to elastic

☐ Add instep strap w/pad ☐ Add toe abduction strap

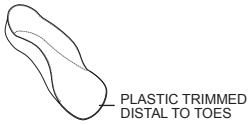
Instep Strap Options: (if applicable) Color: _____ Pattern: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

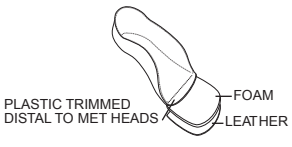
☐ Pattern: _____ ☐ Provide Own Pattern

Toe Shelf

☐ **Flexible Standard**



☐ V



Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 4.5 Softy®

PF resist, DF assist, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

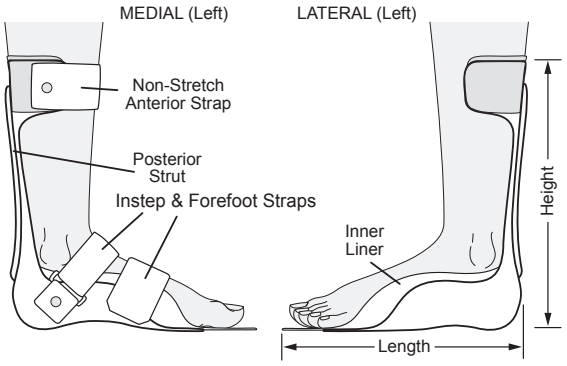
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Posterior Strut: ☐ V ☐ **Standard** ☐ Semi-rigid

Inner Liner:
☐ Polyethylene **Standard**
☐ Co-Poly Foam Color: _____ *(for Co-Poly Liner only)*
☐ Softy foam (white only)
☐ Add extra navicular padding (boney pronators only)

Straps: **Standard** (see drawing)
☐ Add toe abduction strap
☐ Change anterior strap to elastic

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**

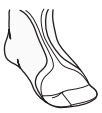
(Outer frame only; additional cost per brace)

☐ Pattern: _____ ☐ Provide Own Pattern

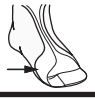
Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf—Inner Liner

☐ **Flexible — no containment Standard**

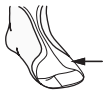


☐ Medial containment:



AND / OR

☐ Lateral containment:



Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® 7

Minimum control foot orthosis (custom HotDog®)

For non-custom HotDogs, use standard prefabricated HotDog form.

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

CAST(S) RECEIVED

☐ Biofoam impressions ☐ Fiberglass or plaster wrap cast

FOREFOOT ALIGNMENT

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

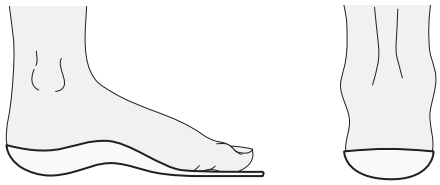
Foam Comfort Layer

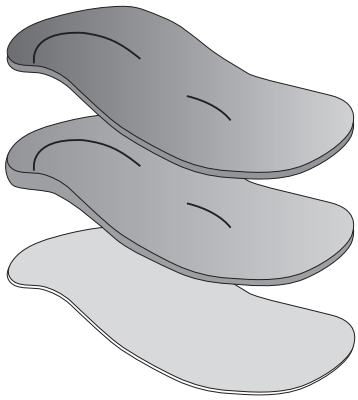
Color: ☐ **Black Standard** ☐ Other: _____

Options

☐ Add Toe Rise Pad

Trimline





Foam Comfort Layer

Cork Supportive Layer

High Density Foam

Arch Support

☐ **Mild Standard**

☐ Moderate

with soft foam)

☐ Firm

Special Instructions

☐ **Rush order** (adds $20)

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® Hemi

AFO for CVA-TBI patients, PF resist, DF assist

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

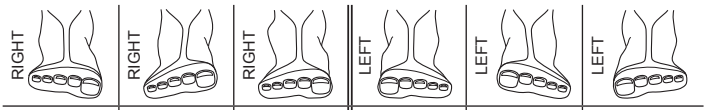
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

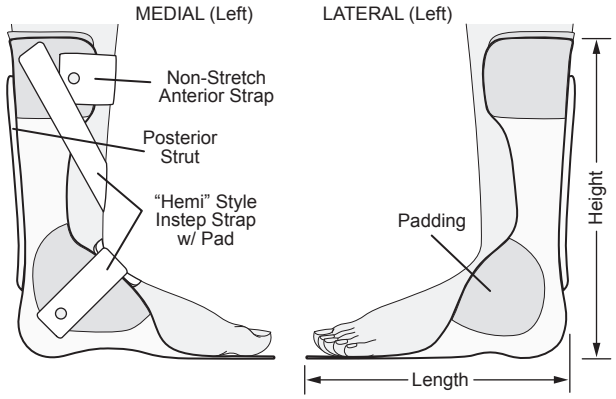
☐ **None—Standard**

☐ Heel

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• **Cast height must be greater than brace height** •

Padding: Shaded areas above are **Standard**

☐ Omit medial pad and / or ☐ Omit lateral pad

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing) ☐ Change instep strap to non-Hemi (straight) strap w/pad.

The Hemi-style instep strap supports one-handed securing—crosses instep to D-ring on lateral side, then crosses the lower leg to a Velcro attachment on upper medial side.

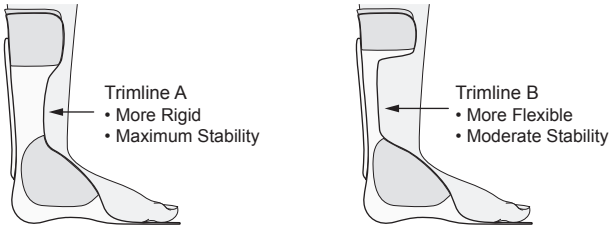
Strap Color: ☐ **White Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Trimlines

☐ **Trimline A Standard** or ☐ Trimline B



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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® R

Regular AFO, PF block

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

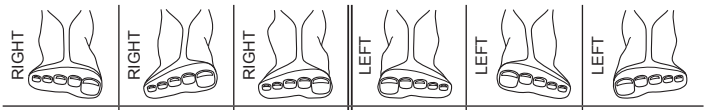
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

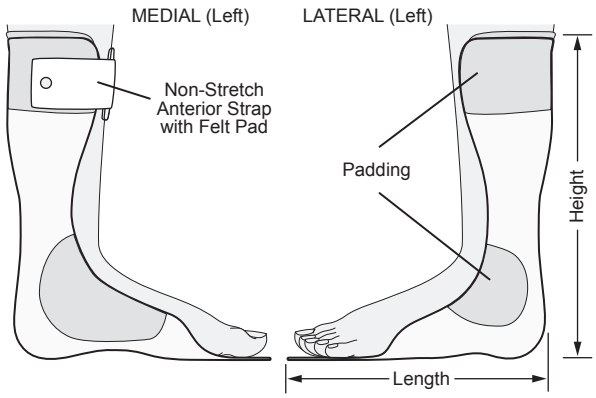
☐ **None—Standard**

☐ Heel

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____

• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**

☐ Omit medial pad and / or ☐ Omit lateral pad

☐ Add extra navicular padding (boney pronaters only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing)

☐ Add toe abduction strap

☐ Add instep strap w/pad

☐ Add D-ring to anterior strap

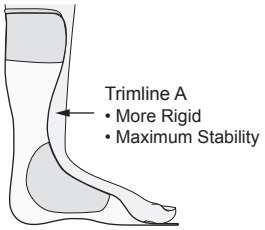
Instep Strap Options: (If applicable) Color: _____ Pattern: _____

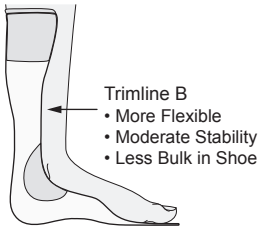
Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Trimlines

☐ **Trimline A Standard** **OR** ☐ Trimline B





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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® TurboH

Hinged PF block

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

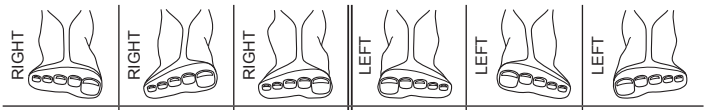
☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.



Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

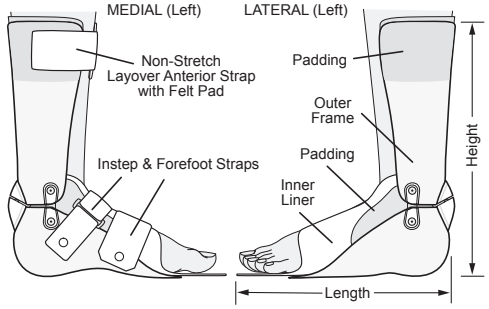
NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

☐ Entire bottom stabilized with foam sole

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

☐ Entire bottom stabilized with foam sole and non-skid cover

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Hinge Type: ☐ **Dorsi-assist Tamarack Standard**
Durometer (95 is stiffest):
☐ **75 d Standard** ☐ 85 d ☐ 95 d
☐ Straight Tamarack

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____
• Cast height must be greater than brace height •

Padding: Shaded areas above are **Standard**
☐ Add extra navicular padding (boney pronators only)

Padding Color: ☐ **White Standard** ☐ Other: _____

Straps: **Standard** (see drawing)
☐ Add toe abduction strap
☐ Add D-ring/pad to anterior strap

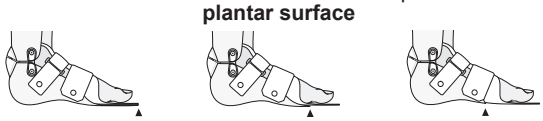
Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**
(Outer frame only; additional cost per brace)
☐ Pattern: _____ ☐ Provide Own Pattern

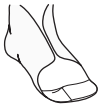
Toe Shelf

Outer Frame:
☐ Full-length under plantar surface (for crouching)
☐ **Standard Trimmed at distal to met. heads under plantar surface**
☐ Trimmed just proximal to met. heads under plantar surface



Inner Liner:

☐ **Flexible — no containment Standard**



Medial containment: ☐ ☐ Plastic

AND / OR

Lateral containment: ☐ ☐ Plastic

Special Instructions

☐ **Rush order** (adds $20)

Thank you!

TO ORDER— 1) SAVE to desktop 2) Fill in eForm 3) Print and send with the patient's cast to Cascade

Clear Form Data

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO TurboH Softy

Hinged PF block, Softy liner

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Finished Brace Angles

ANKLE ALIGNMENT

☐ Correct to 3–4° DF ☐ Correct to _____° ☐ DF ☐ PF ☐ Do not correct (Cast alignment OK)

HINDFOOT ALIGNMENT

☐ Correct to vertical (if misaligned) ☐ Do not correct

FOREFOOT ALIGNMENT **NOTE:**

Choose forefoot alignment. Write posting height if needed—in. or mm.

RIGHT	RIGHT	RIGHT	LEFT	LEFT	LEFT
Valgus	Varus	Neutral	Neutral	Varus	Valgus
☐ ____	☐ ____	☐	☐	☐ ____	☐ ____

Bottom Stabilization

☐ **None—Standard**

☐ Heel **-OR-** ☐ Midfoot **-OR-** ☐ Both

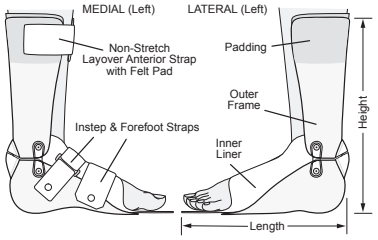
☐ Entire bottom stabilized with foam sole

☐ Entire bottom stabilized with foam sole and non-skid cover

NOTE: Varus or valgus forefoot alignments will receive stabilization on bottom of brace to support posted (raised) region.

NOTE: Neutral forefoot alignments will not see foam on toe shelf.

Construction • Features • Options



NOTE: If you don't choose an option, you will receive the Standard.

Hinge Type: ☐ **Dorsi-assist Tamarack Standard**
Durometer (95 is stiffest):
☐ **75 d Standard** ☐ 85 d ☐ 95 d
☐ Straight Tamarack

Posterior Height: ☐ **⅔ to ¾ of leg length Standard** ☐ Specify: _____
• Cast height must be greater than brace height •

Liner: ☐ **Softy foam (white only) Standard** ☐ Polyethylene
☐ Add extra navicular padding (boney pronators only)
☐ Add plastizote to malleoli (recommended w. PE liner)

Straps: **Standard** (see drawing) ☐ Add D-ring/pad to ant. strap ☐ Add toe abduction strap

Strap Color: ☐ **White Standard** ☐ Other: _____

Instep Strap Pattern: ☐ **No pattern Standard** ☐ Other: _____

Transfer Pattern: ☐ **No Transfer Standard**
(Outer frame only; additional cost per brace)
☐ Pattern: _____ ☐ Provide Own Pattern

Toe Rise and Cuff Padding Color: ☐ **White Standard** ☐ Other: _____

Toe Shelf

Outer Frame:

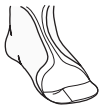
☐ Full-length under plantar surface (for crouching)

☐ Trimmed distal to met. heads under plantar surface

☐ Trimmed just proximal to met. heads under plantar surface

Inner Liner:

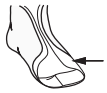
☐ **Flexible — no containment Standard**



☐ Medial containment:

AND / OR

☐ Lateral containment:



Special Instructions

☐ **Rush order** (adds $20)

Thank you!

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Clear Form Data

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | intl +1 360 543 9306
fax 855.543.0092 | www.cascadedafo.com

DAFO® E1 Banana Peel

Fixed position elbow sleeve

Patient

Last name:	
First:	☐ Male ☐ Female
Date cast:	
Birth date:	☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name:	**Title:**	
Facility:		
Street address:		
City:	State:	Zip:
Email:	Phone:	

Billing

☐ Cascade P&O is billing the patient's insurance.		**–OR–**
—UCAN N°:		
☐ **Billing info is the same as practitioner facility.**		**–OR–**
☐ Billing facility:		
Street address:		
City:	State:	Zip:
P.O. N° :		

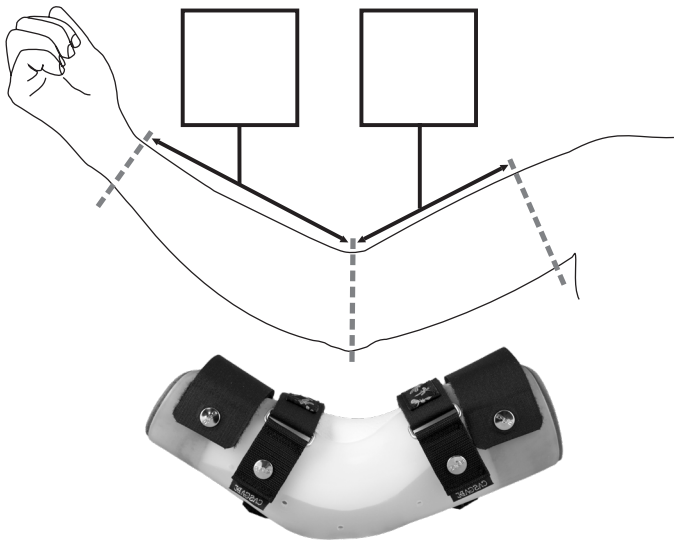
Shipping

☐ Shipping info is the same as practitioner facility.		**–OR–**
Shipping contact name:		
Street address:		
City:	State:	Zip:

Padding • Straps • Trim		
Padding Color:	☐ **White Standard**	☐ Other: _____
Strap Color:	☐ **White Standard**	☐ Other: _____
Strap Pattern:	☐ **No pattern Standard**	☐ Other: _____

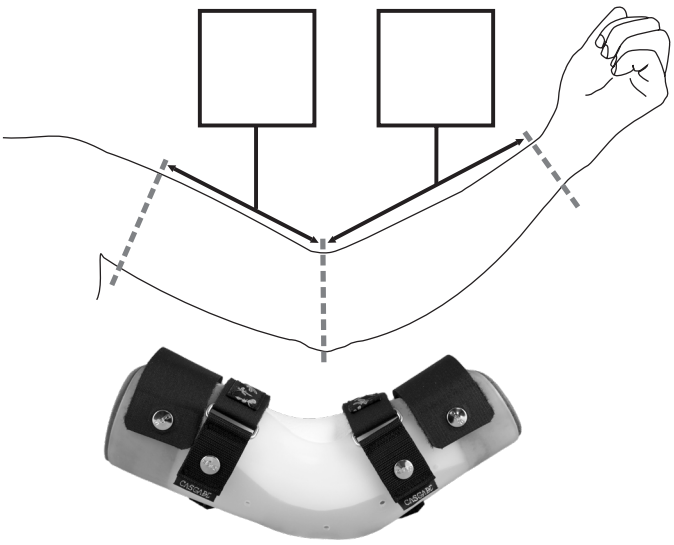
Right Arm

LENGTH



Left Arm

LENGTH



Sleeve Opening

☐ **Anterior—Standard**	☐ Add full-length opening pad (pad riveted in place along opening)
☐ Posterior (dorsal)	

Special Instructions

Cast Information

- ☐ **Fabricate as cast (no correction needed) Standard**
- ☐ Correct elbow angle of cast to _____ (degrees)
- • Cast should span from shoulder to just above wrist.
- •
- Length measurement units — ☐ English ☐ Metric

Thank you!

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® K1 Banana Peel

Fixed position knee sleeve

Patient

Last name:

First: ☐ Male ☐ Female

Date cast:

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

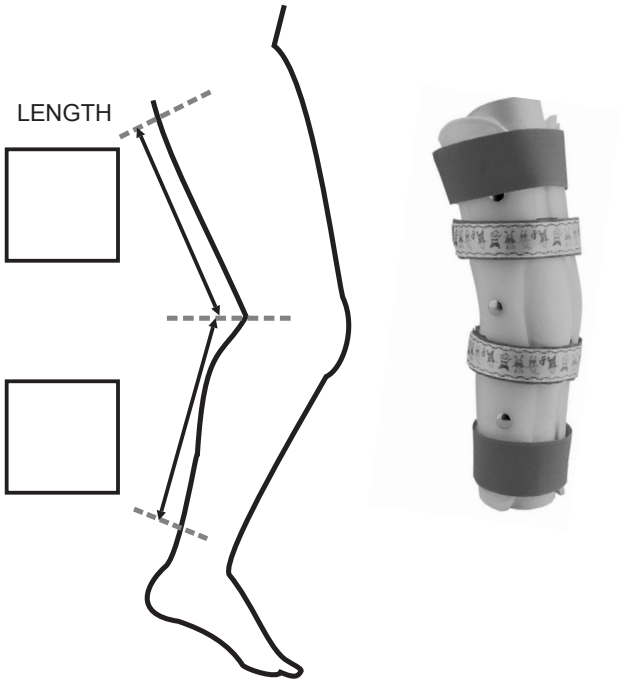
Shipping contact name:

Street address:

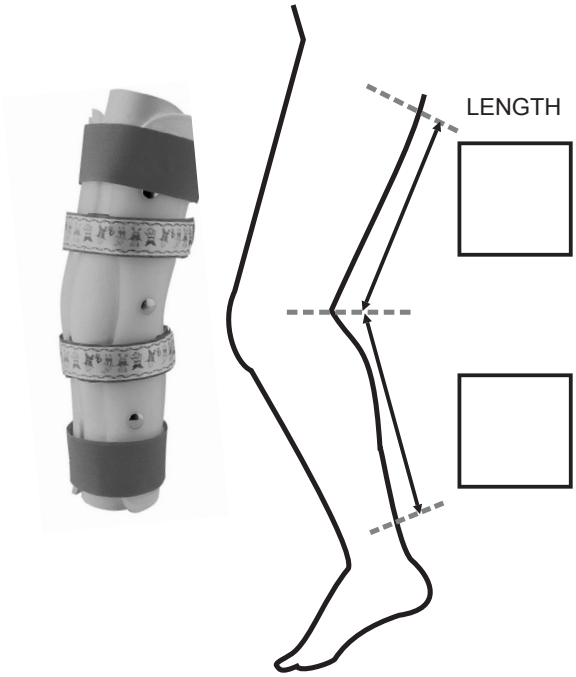
City: State: Zip:

Padding • Straps • Trim		
Padding Color:	☐ **White Standard**	☐ Other: _____
Strap Color:	☐ **White Standard**	☐ Other: _____
Strap Pattern:	☐ **No pattern Standard**	☐ Other: _____

Right Leg



Left Leg



Cast Information

☐ **Fabricate as cast (no correction needed) Standard**

☐ Correct knee angle of cast to _____ (degrees)

• Cast should span from high on thigh to just above the malleoli.
•

Length measurement units— ☐ English ☐ Metric

Special Instructions

Thank you!

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® K3 Knee Brace

Hinged knee extension orthosis

Patient

Last name:

First: ☐ Male ☐ Female

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ **Shipping info is the same as practitioner facility.** **–OR–**

Shipping contact name:

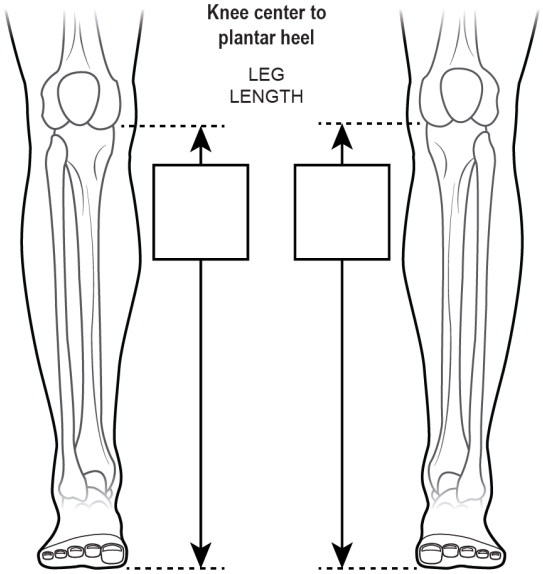
Street address:

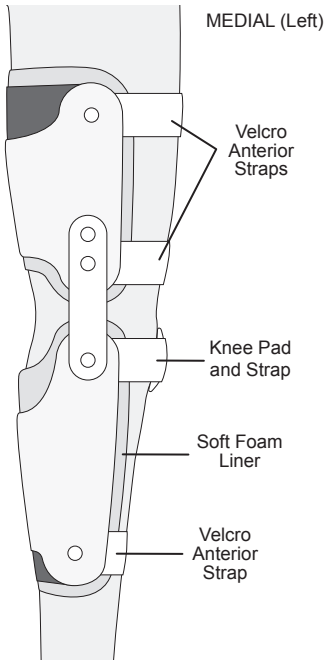
City: State: Zip:

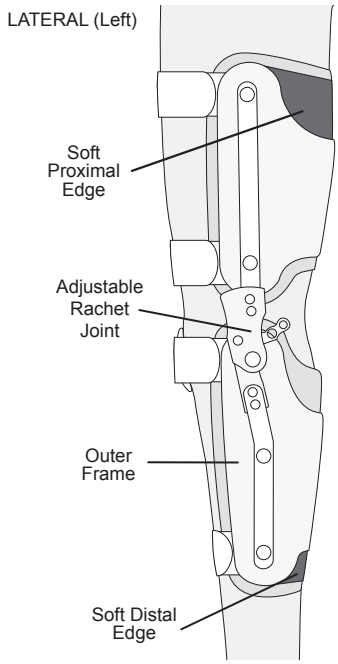
Measurement Information

Order must include a **cast** that spans from near groin to malleolus.

Right Leg **Left Leg**







Liner • Straps • Transfer

Liner Color: ☐ **White Standard** ☐ Black

Strap Color: ☐ **White Standard** ☐ Other: _____

Transfer Pattern: *(Additional cost per brace)* ☐ **No Transfer Standard**

☐ Pattern: _____ ☐ Provide Own Pattern

Special Instructions

Thank you!

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fax 855.543.0092 | **www.cascadedafo.com**

DAFO® KAFO

Knee Ankle Foot Orthotic

Patient

Last name:

First: ☐ Male ☐ Female

Date cast: ☐ **N** ☐ **W**

Birth date: ☐ Bilateral ☐ Left only ☐ Right only

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

NOTE: If you don't choose an option, you will receive the Standard.

AFO Style:

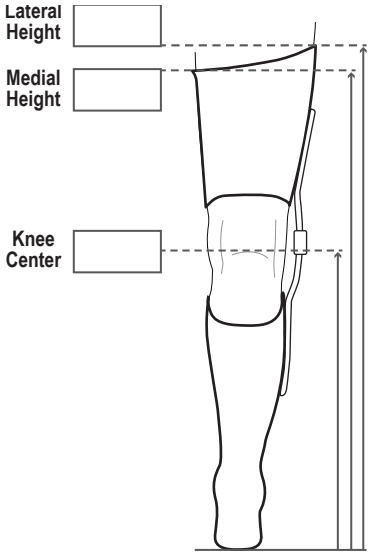
****NOTE: Choose ONE of the four AFO styles below and include the corresponding order form.**

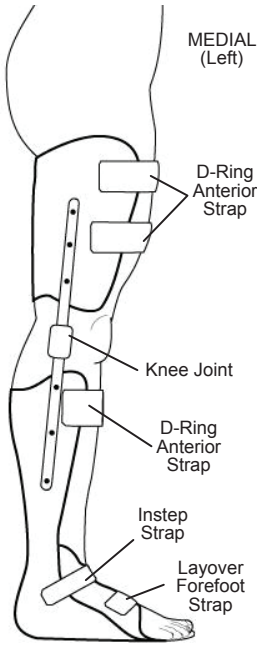
- ☐ **DAFO Turbo Standard**
- ☐ DAFO Turbo Softy
- ☐ DAFO Hinged Turbo
- ☐ DAFO Tami2
- ☐ DAFO R

Special Instructions

Construction • Features • Options

FLOOR TO HEIGHT MEASUREMENTS
All measurements in millimeters (mm)





Knee Joint

Hinge Style:

- ☐ Free (Overlapped / Riveted)
- ☐ Drop Lock
- ☐ Off-set free motion
- ☐ Step lock
- ☐ Adjustable ring lock

Additional Details:

*additional cost items

- ☐ Quick release lever*
- ☐ Quick disconnect*
- ☐ Knee pad*
- ☐ Growth extension bar*

Knee Alignments:

☐ Set Knee Flexion to _____° ☐ (Cast alignment OK) Do not correct

Correct Knee Varus/Valgus to Neutral? ☐ Yes ☐ No

Please Note: A KAFO with a knee center height greater than 18" must be ordered with a cast, not a digital scan.

Thank you!

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ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

DAFO® Twister Straps

De-rotation straps

Patient

Last name:

First:

Birth date: ☐ Male ☐ Female

Practitioner

Name: **Title:**

Facility:

Street address:

City: State: Zip:

Email: Phone:

Billing

☐ Cascade P&O is billing the patient's insurance. **–OR–**

—UCAN N°:

☐ **Billing info is the same as practitioner facility.** **–OR–**

☐ Billing facility:

Street address:

City: State: Zip:

P.O. N° :

Shipping

☐ Shipping info is the same as practitioner facility. **–OR–**

Shipping contact name:

Street address:

City: State: Zip:

Construction • Features • Options

NOTE: If you don't choose an option, you will receive the Standard.

Measurements

Waist Measurement (mm): _____

Waist to lateral malleolus (mm): Left: _____ Right: _____

Straps

Waist Belt: ☐ **Non-Stretch Standard** *(color will match leg strap)* ☐ Neoprene *blue only*

Strap Pattern: ☐ **No Pattern Standard** ☐ Other: _____ See illustration below for placement

Leg Strap: choose one

☐ **Non-Stretch Strap**

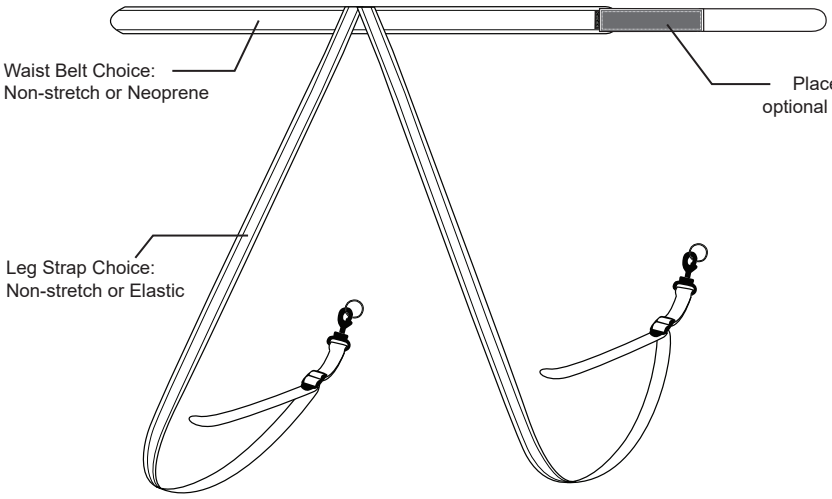
☐ **White Standard** ☐ Black ☐ Beige

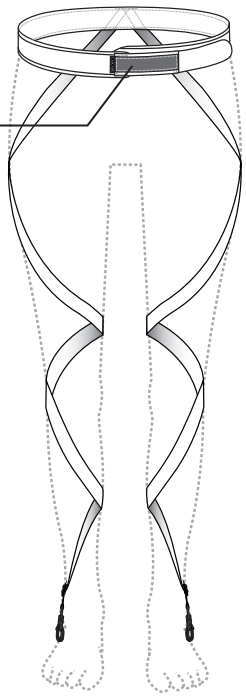
☐ **Elastic Strap**

☐ **White Standard** ☐ Black

Special instructions

☐ **Rush order** (adds $20)





Example:
Worn to encourage *external rotation*

Can be reversed to encourage *internal rotation*

Thank you!

Accessories and Supplies

CASCADE dafo

Cascade Dafo, Inc.
1360 Sunset Ave, Ferndale, WA 98248
ph 800.848.7332 | **intl** +1 360 543 9306
fax 855.543.0092 | **www.cascadedafo.com**

Casting Supplies

Footplate sizes
Available in .25-in. (.64 cm) increments from 4.00 in. (10.2 cm) to 10.75 in. (27.3 cm), in Narrow and Wide.

Item	Description, Sizes	Quantity
Casting Footplates *individual pairs*	Qty ___ Size choose N☐ W☐ Qty ___ Size choose N☐ W☐ Qty ___ Size choose N☐ W☐ Qty ___ Size choose N☐ W☐	0
Casting Footplates *full set*	All sizes, narrow and wide—56 pairs total	
Stockinette, 2 in.	by the yard	
	by the box (25 yards)	
Fiberglass casting tape, 2 in.	by the roll	
	by the box (10 rolls)	
Fiberglass casting tape, 3 in.	by the roll	
	by the box (10 rolls)	
Hook-blade casting knife	Standard utility knife with hooked blade	
Extra hooked blades	Package of 5 double-sided blades	
Black tape	by the roll	
Bio-Foam impression slab	For taking foot impressions. Slab is 13¾ in.(35 cm) x 5⅞ in.(15 cm) x 2¼ in.(5.7 cm). One slab per box. (by the box)	
Nitrile gloves	100 gloves per box. In Quantity column, write box count of each size.	sm / med / large
Channel buffer strip	in 20-in. (50.8 cm) strips	
	by the inch (2.54 cm)	
Scissors	Surgical scissors with angled blades.	
	For carrying your DAFO casting supplies or samples. Ripstop nylon bag with top grab handles, adjustable shoulder strap, and multiple interior and exterior pockets. 17 in.(43.18 cm) x 8 in.(20.32 cm) x 10 in.(25.4 cm)	

For current prices and shipping information,
please call our Customer Support department:

800.848.7332

Billing		
PO #:		
Name:		
Facility:		
Street address:		
City:	State:	Zip:
Phone:	Email:	

Shipping		
☐ **Same as Billing Information**		
Shipping contact name:		
Street address:		
City:	State:	Zip:
Phone:	Email:	

Thank you!