CASCADE dafo

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DAFO® 5

Reset Form

PATIENT

Last Name:	
First Name:	
DOB:	◯ Bilateral ◯ Left ◯ Right

PRACTITIONER

Name:	Title:
Email:	
Phone:	

BILLING ☐ RUSH ORDER($)

Name:	
Address:	
City:	State: Zip:
PO#:	

SHIPPING ☐ Same as Billing

Name:	
Facility:	
Address:	
City:	State: Zip:

NOTE: If no options are selected, you will receive the ***DAFO Standard*** (see illustration).

POSITION OF FUNCTION

BRACE LENGTH:

◯ ***Standard*** ◯ Specify: _____ mm

HINDFOOT ALIGNMENT:

◯ Vertical ◯ Correct Halfway ◯ Do Not Correct

FOREFOOT ALIGNMENT:

◯ Neutral ◯ Varus: _____ mm ◯ Valgus: _____ mm
◯ Do Not Correct

STABILITY

STABILIZATION:

◯ ***Medial Heel-to-Midfoot*** ◯ Heel ◯ Midfoot
◯ Heel-to-Toe ◯ None

NON-SKID:

◯ ***None*** ◯ Vibram

CONTROL

PLANTAR *(OUTER TRIMLINE)*:

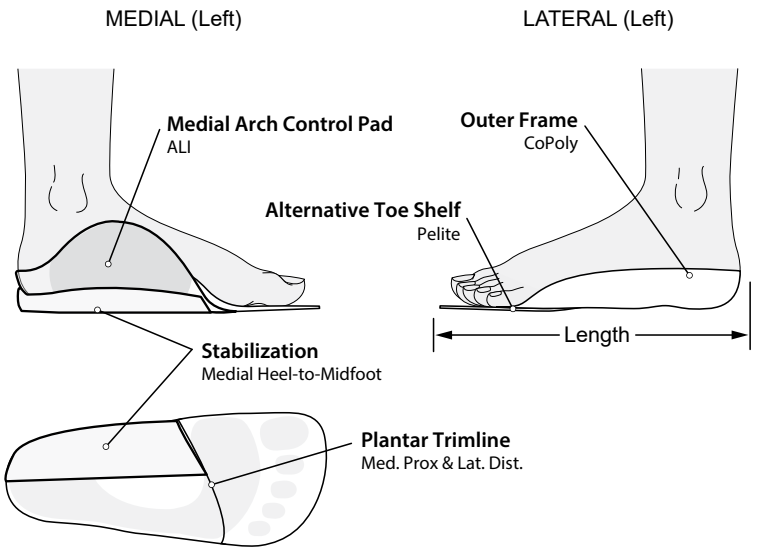
◯ ***Med. Prox & Lat. Dist*** ◯ Full Length

ALTERNATIVE TOE SHELF:

◯ ***Pelite*** ◯ None

TOE RISE:

◯ ***Toe Rise*** ◯ Toe Rise w/ Abduction Strap



COMFORT

TALUS & NAVICULAR PADDING:

◯ ***None*** ◯ Add PPT

COSMETIC

ALIPLAST PAD COLOR:

◯ ***White*** ◯ Specify: _____

TRANSFER:

◯ ***None*** ◯ Specify: _____

ADDITIONAL INSTRUCTIONS