DAFO® K3 Knee Brace™

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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

KNEE CENTER HEIGHT:

Specify: _____ ***mm***

COSMETIC

ALIPLAST PAD COLOR:

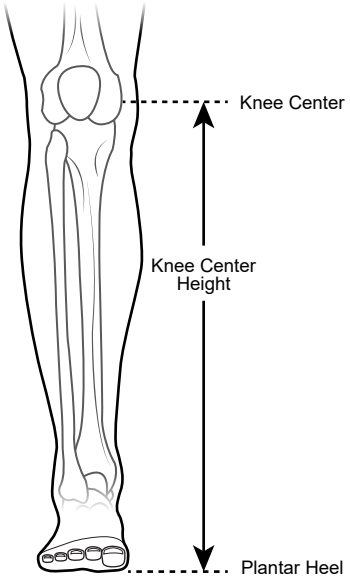
◯ ***White*** ◯ Black

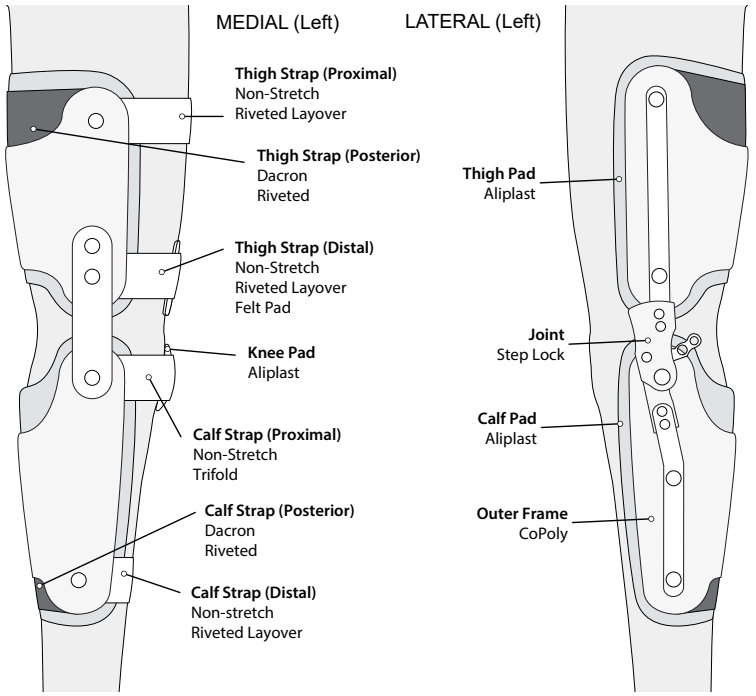
STRAP COLOR:

◯ ***White*** ◯ Specify: _____

TRANSFER:

◯ ***None*** ◯ Specify: _____





ADDITIONAL INSTRUCTIONS