CASCADE dafo

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DAFO® KAFO

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).

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

AFO STYLE

DAFO BRACE STYLE:

◯ DAFO Turbo ◯ DAFO Turbo Softy
◯ DAFO Tami 2 ◯ DAFO R

POSITION OF FUNCTION

THIGH HEIGHT (LATERAL):

◯ ***Standard*** ◯ Specify: _____ mm *(measured from plantar heel)*

THIGH HEIGHT (MEDIAL):

◯ ***Standard*** ◯ Specify: _____ mm *(measured from plantar heel)*

KNEE ALIGNMENT:

◯ Specify: _____ ° *(degrees)* ◯ Do Not Correct

KNEE VARUS/VALGUS:

◯ ***Neutral*** ◯ Do Not Correct

CONTROL

JOINT:

◯ ***Steplock*** ◯ Drop Lock ◯ Adjustable Ring Lock
◯ Off-Set Upright ◯ Post. Off-Set Free Motion ◯ None

JOINT ADD-ON:

◯ ***None*** ◯ Quick Release Lever ($) *(Only applicable with Step Lock joint)*
◯ Quick Disconnect ($) ◯ Growth Extension Bar ($)

KNEE PAD:

◯ ***None*** ◯ Add Knee Pad($)

COSMETIC

ALIPLAST PAD COLOR:

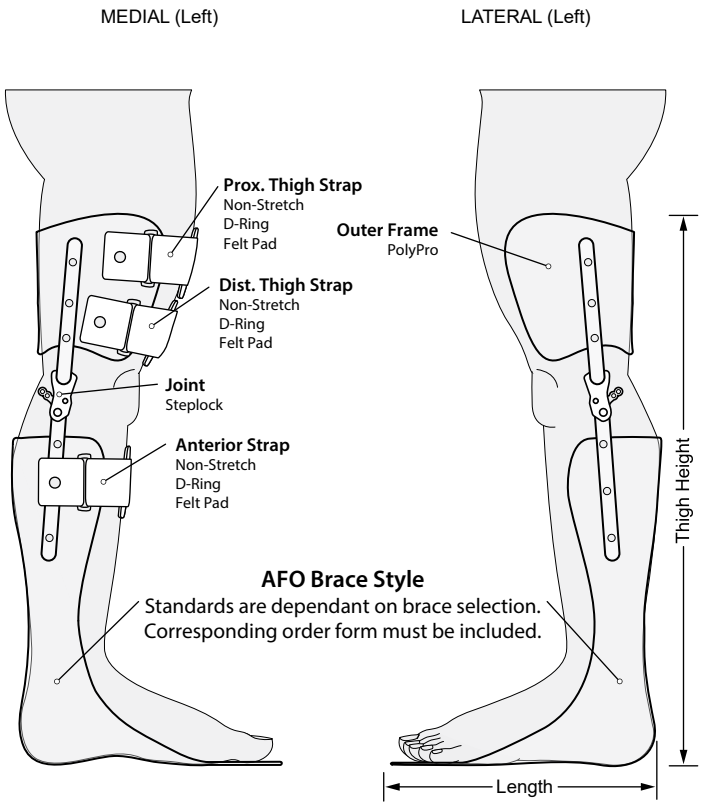
◯ ***White*** ◯ Specify: _____

STRAP COLOR:

◯ ***White*** ◯ Specify: _____

TRANSFER:

◯ ***None*** ◯ Specify: _____



ADDITIONAL INSTRUCTIONS