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DAFO® Twister Straps

Reset Form

PATIENT

Last Name:	
First Name:	
DOB:	

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

WAIST MEASUREMENT:

Specify: _____ ***mm***

WAIST-TO-LATERAL MAL. MEASUREMENT:

Specify: _____ ***mm***

CONTROL

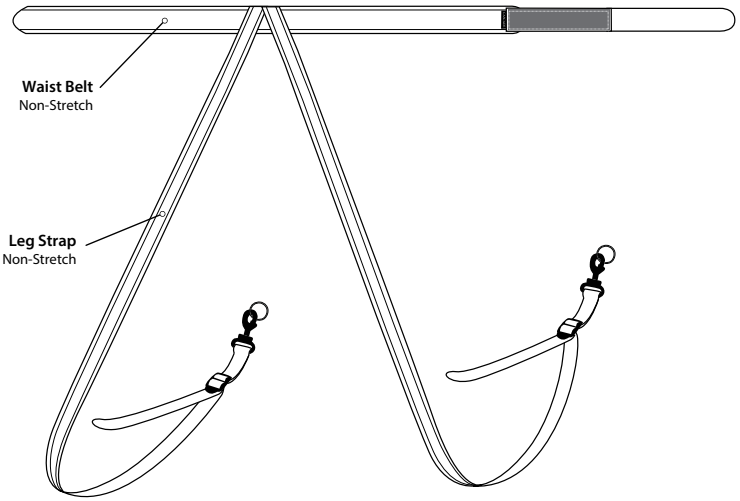
LEG STRAP:

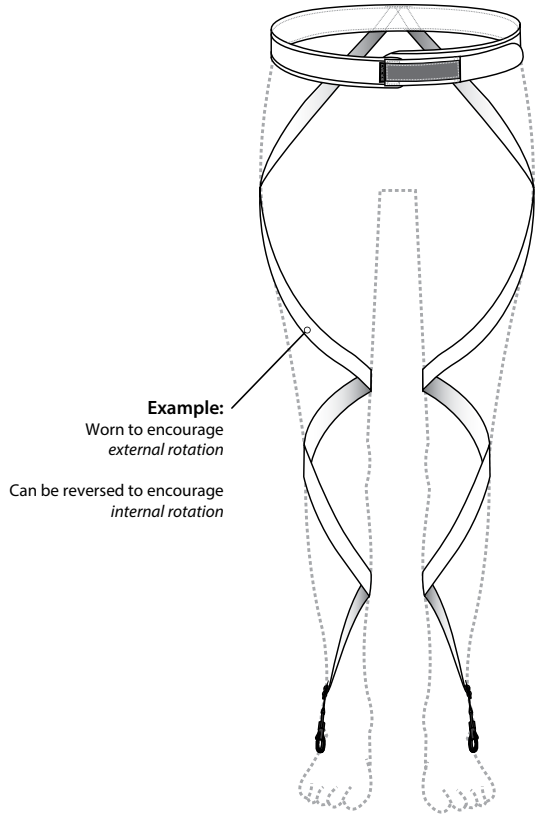
◯ ***Non-Stretch*** ◯ Elastic

COSMETIC

STRAP COLOR:

◯ ***White*** ◯ Black





Example:
Worn to encourage
external rotation

Can be reversed to encourage
internal rotation

ADDITIONAL INSTRUCTIONS