THUASNE®

SpryStep® Agilik™ KAFO

Specialty Bracing

Contact Information

☐ Clinician ☐ Fitter/Assistant/Tech ☐ Other: _____

Name: _____

Email: _____ Phone: _____

Ordering Clinician

☐ CPO ☐ CO ☐ CP ☐ Other: _____

Name: _____

Email: _____ Phone: _____

Billing & Shipping

PO#:

Billing Account#: _____

Shipping Account#: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____

Shipping Preference

☐ Ground ☐ Next Day AM ☐ Next Day PM ☐ 2-Day AM ☐ 2-Day PM

(If no preference is indicated, this order will be shipped 2 Day PM) Note: We do not ship products directly to patients.

Patient Information

By filling this order form and placing an order for this device, I hereby certify that I am authorized to dispense this medical device in virtue of any national law governing the fitting and adjustment of orthopedic medical devices

Please do not provide any personal information (name etc) regarding the patient, but only provide health information necessary to the fabrication of this medical device

Fit Date: _____ **Patient ID:** _____

Age _____ ☐ **Male** ☐ **Female**

Weight _____ ☐ *Lbs.* ☐ *Kg.* **Height** _____ ☐ *in.* ☐ *cm.*

Leg: ☐ Left ☐ Right

Diagnosis: _____

Surgeries *(type/date):* _____

Is the patient currently using any assistive device?

☐ Brace/KAFO ☐ Crutch ☐ Wheel Chair
☐ Cane ☐ Walker

Shoe Size: _____

☐ Appropriately scaled tracing of shoe insole provided with order form

☐ Not sending shoe or tracing *(toe segment will be made longer and wider, requiring trimming during fitting)*

PLEASE PROVIDE MEASUREMENTS

Shoe Height Measurement (Shoe sole thickness at heel and forefoot)

Heel _____ ☐ *in.* ☐ *cm.*

Forefoot _____ ☐ *in.* ☐ *cm.*

Cast Info

Cast Adjustments Required *(coronal and sagittal plane)*

_____

_____

Extended Warranty

☐ 1yr. ☐ 2yrs. ☐ 3yrs. ☐ 4yrs.

(Agilik Component Only)

Range Of Motion

a. Hip ROM: _____ ° extension to _____ ° flexion

b. Knee ROM: _____ ° extension to _____ ° flexion

c. Ankle ROM, with knee extended

Dorsi-Flexion _____ °

Plantar-Flexion _____ °

d. Plantarflexion contracture

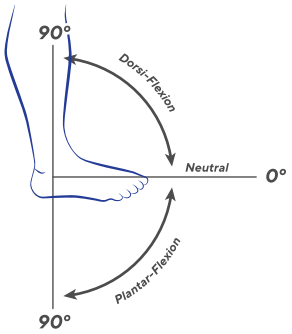
☐ Yes _____ ° ☐ No

e. Knee flexion contracture

☐ Yes _____ ° ☐ No

f. Hip flexion contracture

☐ Yes _____ ° ☐ No



Activity Level *(Check one)*

☐ Limited ambulator: sits to stands and transfers
☐ Household ambulator: level surfaces with walking aids
☐ Limited community ambulator: level surfaces with walking aids
☐ Active community ambulator: mild inclines and declines with or without walking aids
☐ Independent ambulator: varied cadence, uneven surfaces and no walking aids
☐ Active ambulator: walking, running, some athletic activity

Biomechanical objectives

☐ Resist Knee Hyperextension in Stance
☐ Resist Knee Flexion in Stance
☐ Knee Valgus Control
☐ Knee Varus Control
☐ Posterior/Anterior Knee Drawer Control
☐ Control Dorsiflexion Weakness
☐ Control Plantar Flexion weakness
☐ Control Ankle Valgus Instability
☐ Control Ankle Varus Instability

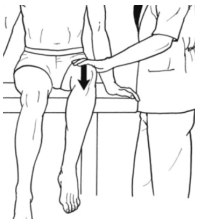
OF073 - Rev B

Received Date *Thuasne USA's shipping department use only*

Distributed by Thuasne USA
4615 Shepard Street, Bakersfield, CA 93313
Tele: 800.432.3466 • Fax: 844.261.5628
ThuasneUSA.com

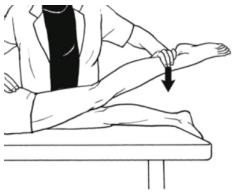
Manual Muscle Strengths

Hip Flexor strength



	Left	Right
0	☐	☐
1	☐	☐
2	☐	☐
3	☐	☐
4	☐	☐
5	☐	☐

Hip Extensor strength



	Left	Right
0	☐	☐
1	☐	☐
2	☐	☐
3	☐	☐
4	☐	☐
5	☐	☐

Quadriceps strength

	Left	Right
0	☐	☐
1	☐	☐
2	☐	☐
3	☐	☐
4	☐	☐
5	☐	☐

Hamstring strength

	Left	Right
0	☐	☐
1	☐	☐
2	☐	☐
3	☐	☐
4	☐	☐
5	☐	☐

Dorsiflexion strength

	Left	Right
0	☐	☐
1	☐	☐
2	☐	☐
3	☐	☐
4	☐	☐
5	☐	☐

Plantar-flexor strength

Number of Single Limb Heel Raises	
Left	Right

Notes:

Measurements

Measurements below are in: ☐ in. ☐ cm.