CASCADE dafo

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DAFO® Turbo Softy®

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 HEIGHT:

Standard Specify: __________ mm

BRACE LENGTH:

Standard Specify: __________ mm

ANKLE ALIGNMENT:

3° DF ________ ° DF ________ ° PF Do Not Correct

HINDFOOT ALIGNMENT:

Vertical Correct Halfway Do Not Correct

FOREFOOT ALIGNMENT:

Neutral Varus: _______ mm Valgus: _______ mm
Do Not Correct

STABILITY

STABILIZATION:

None Heel Midfoot Heel-to-Midfoot Heel-to-Toe

NON-SKID:

None Vibram

CONTROL

INNER LINER:

Softy Foam Polyethylene OP Flex ($)

PLANTAR *(OUTER TRIMLINE)*:

Full Length (*STANDARD FOR SOFTY FOAM LINER*) Distal to Met. Head (*STANDARD FOR POLYETHYLENE LINER*) Proximal to Met. Head

LATERAL MET. HEAD *(OUTER TRIMLINE)*:

At Met. Head Distal Proximal Long Containment

MEDIAL MET. HEAD *(OUTER TRIMLINE)*:

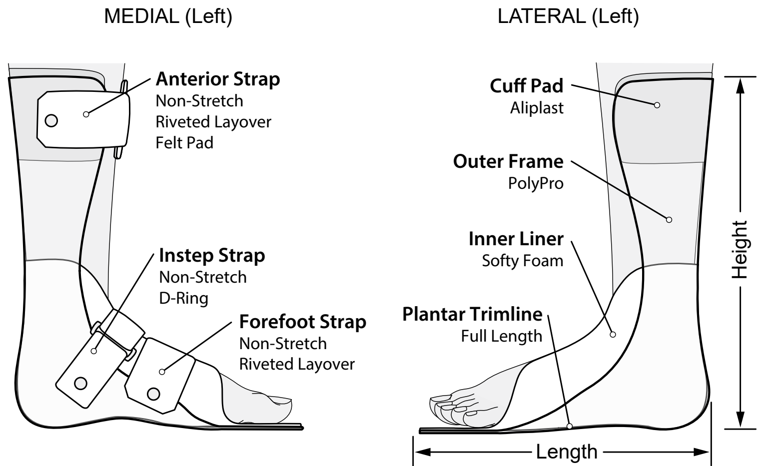
At Met. Head Distal Proximal Long Containment

SOFT CONTAINMENT:

None Lateral Medial Lateral & Medial

TOE RISE:

Toe Rise Toe Rise w/ Abduction Strap



COMFORT

TALUS & NAVICULAR PADDING:

None Add PPT

COSMETIC

ALIPLAST PAD COLOR:

White Specify: ____________________

STRAP COLOR:

White Specify: ____________________

TRANSFER:

None Specify: ____________________

ADDITIONAL INSTRUCTIONS

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