SPINAL ORTHOSIS EVALUATION FORM

Patient: _____ DOB: _____ HT: _____ Wt: _____ Sex: M F

Date of onset: _____ Diagnosis: _____ ICD10: _____

Referring Physician: _____ Services Referred for : _____
_____

Living Status: ☐ Alone or without assistance ☐ Long-term care facility ☐ Home with assistance
☐ Other: _____
Allergies: ☐ N/A if yes: _____

Assistive Devices?: ☐ N/A ☐Handrail ☐ Ramp ☐ Cane ☐Crutches ☐ Walker ☐ Wheelchair ☐Other

Describe mechanism of injury or onset of disease, including dates, surgeries, etc.

Describe impact of injury/ disease on patient functional abilities, including motion sensation, etc.

Does the patient currently wear a spinal orthosis? ☐ No ☐Yes: (Describe)_____

Age of Ox: _____ Hours worn daily: _____ Have they had additional spinal Ox: ☐ Yes ☐ No
Why does Ox need to be replaced?: _____

Functional goal(s) discussed for new orthosis:
☐ To reduce pain by restricting mobility of the trunk
☐ To facilitate healing following an injury to the spine or related soft tissues
☐ To facilitate healing following a surgical procedure on the spine or related soft tissue
☐ To otherwise support weak spinal muscles and/or a deformed spine

Indicate the type of condition being treated and detail how this particular device will provide the desired clinical outcome
☐ Treatment of a chronic condition: _____
_____
☐ Acute injury: _____
_____

☐ Post surgical: _____
_____

☐ Other:_____
_____

Patient Name: _____

What type of spinal orthosis is to be provided? (Provide details below as to the need for a custom design)

☐CTLSO ☐TLSO ☐LSO ☐ Design: ☐ Plastic: ☐ Single opening ☐ Bivalve ☐ Metal ☐ Flexible/elastic with/without stay (s) ☐ Fabric (Cotton/nylon/canvas etc.) ☐ Other
Manufacturer:_____ Model #:_____ Size: _____

OTS (Off-the-shelf) design rationale ☐ N/A
☐ Does NOT require clinical expertise to be fit to patient
☐ Does NOT require modification to achieve an appropriate fit and function

Custom Fit design rationale ☐ N/A
☐ Device requires clinical expertise to be modified to achieve an appropriate fit/function
☐ Patient requires a custom fitted modification to the orthosis secondary to clinical issues that an OTS device cannot provide; Explain: _____

Custom Fabricated design rationale ☐ N/A
☐ Patient will not fit into prefabricated system due to size and/or anatomical anomalies
☐ Boney prominence (circle all that apply) ASIS sternum/chest ribs spine Other:_____
☐Distended stomach
☐ Abnormal tissue, explain:_____
☐ Fragile skin
☐ Obese or fitting outside anthropomorphic normal sizing
☐ Short stature and/or stout
☐ Excessive thoracic kyphosis
☐ Other:_____

☐Prefabricated system will not provide adequate support
☐ Lordosis does not fit within normal standard deviations of prefabricated orthoses
☐ Other: _____

☐ Custom orthosis requires special modifications to achieve appropriate functional outcome
☐ Proper hyperextension to unload fracture site cannot be achieved with prefabricated design
☐ Required lordotic support with sternal pressure required to achieve a proper 3-point pressure system

☐ Other: ☐ A full plastic design with no fabric will allow for cleaning of TLSO

Casting or measurements at today's appointment?: ☐ No ☐ Yes, What was done?:
☐ Casting with fiber glass or plaster ☐Measurements using Spinal Tech form
How was/were the cast or measurements obtained?: ☐ Standing ☐ Supine

Fitting/ Delivery: ☐ When called ☐ Specific date: _____ ☐ Other:_____
Did the patient tolerate the evaluation without incident/problem? ☐ Yes ☐ No (explain): _____

Practitioner: _____ Signature: _____
Date: _____