SpryStep® Vector 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

Fit Date: _____

Initials: _____   **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: _____

☐ Patient's shoe shipped with cast
☐ 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)*
☐ Tracing of foot taken, semi-weight bearing

PLEASE PROVIDE MEASUREMENTS
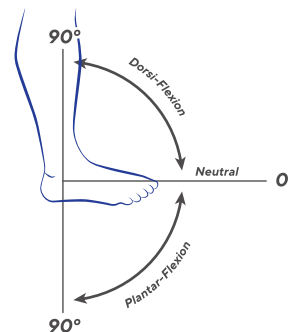**Shoe Height Measurement** (Shoe sole thickness at heel and forefoot)

Heel _____ ☐ *in.* ☐ *cm.*

Forefoot _____ ☐ *in.* ☐ *cm.*

*Indicates additional charges apply

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

Cast Info

Cast Adjustments Required *(coronal and sagittal plane)*

_____

_____

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

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

Brace Configuration

Shell Configuration

| 1 | 2 | 3 | 4 |
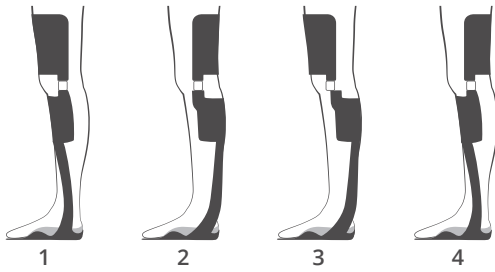
- ☐ Anterior (1)
- ☐ Posterior (2)
- ☐ Hyperextension Resist (3)
- ☐ Flexion Resist (4)

Coronal Plane Extension

- ☐ Valgus Resist
- ☐ Varus Resist

Molded Inner Boot

- ☐ Low
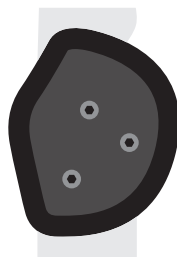- ☐ Dorsal wrap

- ☐ Leave inner boot unattached

Strap Options

- ☐ Include ankle strap
- ☐ Leave ankle strap unattached

Knee Joint Options

- ☐ Single Pivot Locking **37700-L** *(Manual Triggers)*
- ☐ Single Pivot Locking* **37700-L** *(Twist Release with free motion)*
- ☐ 5-bar Free **37700**
- ☐ 5 Bar Locking **37700-L** *(Manual Triggers)*
- ☐ 5 bar Locking* **37700-L** *(Twist Release with Free motion)*

Twist Release Position

- ☐ Lateral *(always lateral if configuration 2 or 4)*
- ☐ Anterior
- ☐ Anterio-medial

Extension Assist

- ☐ Install Extension Assist Bands/Posts

Measurements

Measurements below are in: ☐ *in.* ☐ *cm.*

- Proximal Thigh Band
- Mid Thigh
- Knee Center
- Fibula Head
- Ankle
- Circumference Measurements
- Ankle Height
- Maximum Height of AFO
- Knee Center Height
- Mid-thigh Height
- Maximum Height of KAFO

Knee medial-lateral width

Ankle medial-lateral width

Toe-out