AFO FOR USE DURING AMBULATION

Beneficiary Name: ___________________ Date of Birth: _______ Date of Examination:________________

Height: ________________ Weight: (please indicate loss or gain): _________________________

a. History of injury, illness or condition including:

Diagnosis (diagnoses): ____

Affected side(s): ____

Symptoms: ____

Clinical Course: ____

Therapeutic interventions/results: ____

Prognosis: ____

b. Description of nature & extent of functional limitations on a typical day: ________________

c. Status of current orthosis condition, if applicable: ____________________________________

CARDIOPULMONARY EXAM: ____

MUSCULOSKELETAL EXAM: ____

ARM/LEG STRENGTH: ____

NEUROLOGICAL EXAM: ____

GAIT/BALANCE/COORDINATION: ____

I certify that the above named beneficiary is under my medical care and requires the orthotic services I have prescribed for the diagnosis (diagnoses) as specified above.

1. ____ The beneficiary has weakness and/or deformity of the foot, and/or foot drop, and/or requires stabilization of the foot and ankle for the reasons as specified above.

2. ____The beneficiary could not be fit with a prefabricated AFO; or the beneficiary's condition is expected to be permanent or of longstanding duration.

3. ____ The beneficiary has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury.

4. ____This beneficiary has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

5. ____This beneficiary has the potential to benefit functionally from the use of an AFO.

6. ____ Other as outlined above.

This plan of treatment is being established under my direct care and in conjunction with the beneficiary's orthotist. I certify that this plan of care is appropriate and medically necessary for this beneficiary.

Physician's Signature: ____Date:________________