FITTER ACKNOWLEDGMENT FORM- KNEE (OA)

PATIENT INFORMATION

Name (Last, First): _____
Patient ID#:
DOB: _____/_____/_____

Please attach product barcode sticker
-OR-
write description here

Service location: (___) Home (___) HCP's Office (___) PSC (___) Hospital: _____ (___) Other: _____

Patiently currently resides at: (___) Home (___) SNF (___) Other: _____

STEP 1: MEASUREMENT(S)

(___) Height: _____ (___) Weight: _____
(___) Upper Thigh: _____ (Circumference 6" above mid-patella)
(___) Mid-Thigh: _____ (Circumference 3" above mid-patella)
(___) M-L: _____
(___) Upper Calf: _____ (Circumference 3" below mid-patella)
(___) Lower Calf: _____ (Circumference 6" below mid-patella

Explain **WHY** adjustment more than the minimal self -adjustments is required: *** Include time spent***

_____
_____
_____

STEP 2: CUSTOMIZE SIZING

(___) STRAP 1: (___) NO (___)YES- Amount Adjusted/Cut _____
(___) STRAP 2: (___) NO (___)YES- Amount Adjusted/Cut _____
(___) STRAP 3: (___) NO (___)YES- Amount Adjusted/Cut _____
(___) STRAP 4: (___) NO (___)YES- Amount Adjusted/Cut _____
TIME SPENT: _____

STEP 3: SET PRESCRIBED RANGE OF MOTION

Is range of motion control required by ordering physician? (___) YES (___) NO
(___) Flexion set at: _____
(___) Extension set at: _____
(___) Quarter turns needed: _____
TIME SPENT: _____

STEP 4: EDUCATE PATIENT ON THE CARE/USE OF THE BRACE

(___) How to use the unloading mechanism
(___) How to DON and DOFF the brace was taught
(___) Proper strapping steps to help with suspension
(___) Proper placement of brace
(___) Proper cleaning
(___) Follow up appointments
TIME SPENT: _____

STEP 5: REASON FOR CUSTOMIZING PREFABRICATED ORTHOTIC

1. Did the fit require more than minimal self-adjustment that required customizations to a specific patient at time of fitting? (___) YES (___) NO
If YES, check all that apply:
(___) Patient's anatomy did not fit properly into OTS brace
(___) Hinge(s) did not fit properly into the patient's anatomy
(___) Straps did not fit properly into the patient's anatomy
(___) Fabri/Material was causing the brace not to fit properly into the patient's anatomy
(___) Patient had pressure points that needed to be adjusted on the brace
(___) Other
2. Did the modification(s) above require someone with expertise to complete them? (___) YES (___) NO

STEP 6: FURTHER JUSTIFICATION (IF NEEDED)

Further clinical justification for customizing brace:

_____
_____
_____
_____

TOTAL TIME SPEN WITH PATIENT ON BRACE: _____
MODEL OF TREND BRACE: _____

NOTE TO CLINICIAN- SERVICES/ACTIONS

Ensure you have addressed the following during your interaction with this patient: a) Assess the orthosis for structural safety and ensure that the manufacturer guidelines are followed prior to fitting (e.g., patient's weight limits, ensuring closures work properly, etc.) and ensure the orthosis is fit properly; b) Provide education, training, and/or written instructions on the use and function of the orthosis, key components and features of the orthosis, application and removal of the orthosis, and care and cleaning of the orthosis; c) Provide written instructions for obtaining needed follow up services and instruct the patient to communicate to the staff any service/product problems; and d) Confirm warranty information was provided to the patient as part of the POD.

By my signature below, I affirm that the information above is true and accurate, and that I personally conducted the assessment and custom fitting (if applicable) on the date noted below:

Clinician/Fitter Signature: _____ Date: _____/_____/_____ □ Check if Prescribing Clinician

Name (Print): _____ Title/Credentials: _____

Orthotist/Prescribing Clinician Signature (if applicable): _____ Date: _____/_____/_____

Name (Print): _____ Title/Credentials: _____