

BILL TO:

Practitioner: _____

P.O.#

O&P Facility: _____

E-mail: _____

Phone: _____

Ship To (if different): _____

Shipping Method:

- UPS Ground (No Charge)
- 3 Day Ground
- Blue
- Red
- Red Early

Address: _____

Address: _____

City: _____

City: _____

State: _____

Zip: _____

State: _____

Zip: _____

Patient : _____

Ht: _____ Wt: _____ Age: _____ LOM (in degrees): _____

Primary Dx: _____

Affected Limb's Skin Integrity (circle one) POOR FAIR GOOD

Secondary Dx: _____

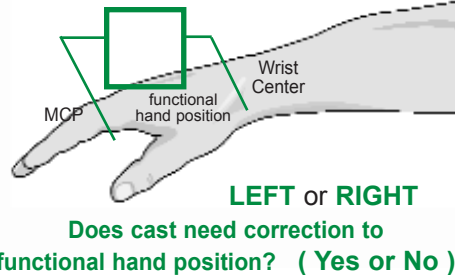
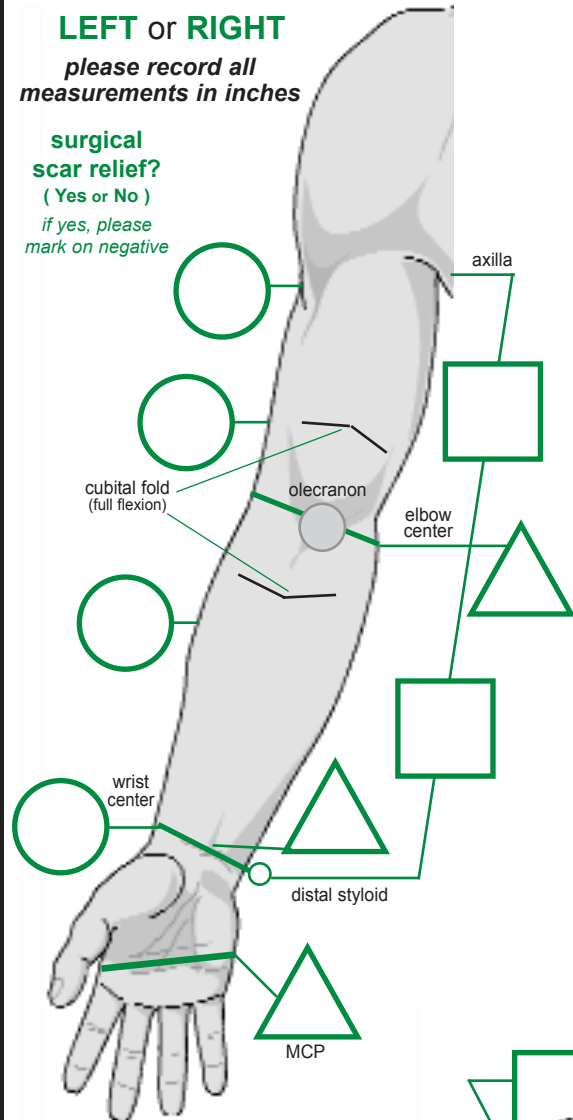
Affected Limb's Circulation (circle one) POOR FAIR GOOD

Affected Limb's Sensation (circle one) POOR FAIR GOOD

ATTN: BEFORE CASTING, PLEASE REVIEW CONSIDERATIONS (located on reverse side)

LEFT or RIGHT
please record all measurements in inches

surgical scar relief? (Yes or No)
if yes, please mark on negative



LEFT or RIGHT

Does cast need correction to functional hand position? (Yes or No)

(M/L)	(R/U)	(MCP)
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ELBOW	WRIST	MCP
MEDIAL: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit extension <input type="checkbox"/> limit flexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> extension assist <input type="checkbox"/> flexion assist LATERAL: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit extension <input type="checkbox"/> limit flexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> extension assist <input type="checkbox"/> flexion assist	RADIAL: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit extension <input type="checkbox"/> limit flexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> extension assist <input type="checkbox"/> flexion assist <input type="checkbox"/> sup/pro assist ULNAR: TYPE: <input type="checkbox"/> pediatric <input type="checkbox"/> adult <input type="checkbox"/> other _____ STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit extension <input type="checkbox"/> limit flexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check all that apply) <input type="checkbox"/> extension assist <input type="checkbox"/> flexion assist <input type="checkbox"/> sup/pro assist	STATIC CONTROLS: (check all that apply) <input type="checkbox"/> limit extension <input type="checkbox"/> limit flexion <input type="checkbox"/> full lockout ASSIST NEEDED: (check only one) <input type="checkbox"/> extension assist <input type="checkbox"/> flexion assist CLOSURES HUMERAL: <input type="checkbox"/> rigid <input type="checkbox"/> flexible <input type="checkbox"/> straps/pads FOREARM: <input type="checkbox"/> rigid <input type="checkbox"/> flexible <input type="checkbox"/> straps/pads HAND: <input type="checkbox"/> rigid <input type="checkbox"/> flexible <input type="checkbox"/> straps/pads HAND TRIMLINES: <input type="checkbox"/> full handpiece <input type="checkbox"/> MCP trim <input type="checkbox"/> other _____ THUMB ENCLOSURE: <input type="checkbox"/> full closed <input type="checkbox"/> open <input type="checkbox"/> channel <input type="checkbox"/> spica

Notes:

PLASTIC: Blue HDPE (standard) .140 - .187

HDPE: Yellow.140 Black.140, .187 Red.140 White.140, .187 Pink.125 Purple.125

POLYPRO .187:

Black White

STRAPS:

Black White

FOAM: 1/4" (standard)

1/8" 3/8"

Casting Considerations for Ultraflex Custom Molded Orthoses

UPPER EXTREMITY

- 1) Patient evaluation should generally follow ABC “SOAP” procedures - Subjective, Objective, Assessment, & Plan and specifically follow the Ultraflex Manual-Catalog. Note: evaluations & orthoses designs differ for ortho & neuro patients.
- 2) Document all anatomic landmarks & measurements noted on Ultraflex Custom Fabrication Order Form.
- 3) Cast affected limb, maximizing levers inferior & superior to joint, spanning 2/3 to 3/4 of each limb segment. Note areas of open wounds, skin grafts, etc... (that require relief or modification) directly on cast stockinette.
- 4) Introduce gentle hand pressure to extend or flex the limb (as applicable) in the direction of intended correction. For cases requiring both flexion & extension correction, cast in a comfortable mid-range position.
- 5) Place casting tube opposite of where intended shells will provide force (to minimize obscuring anatomy at points of body interface). For example, on a flexion assist KO, place tube on posterior aspect for an anterior shell brace design.

Typical limb postures for orthopedic indications

Orthopedic

Elbow

Elbow should be in midrange with wrist neutral in all planes (“handshake”)



Wrist

Wrist should be in intrinsic plus position



Neurological

Elbow-Wrist Flexor/Pronator Spasticity

Forearm to neutral or to full supination to extent feasible



Elbow-Wrist FirstFlex™ Orthosis

Wrist in intrinsic plus position,
drop wrist as necessary



Call Ultraflex Clinical Technical Support at 1-800-220-6670 for any questions.