

CLINICARE FAX ORDER FORM: (800) 603-3939

Facility Name: _____ Date: _____

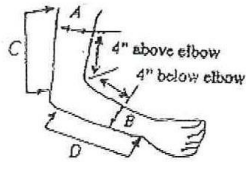
Patient Name: _____ On this date: Med A Med B

Ship to the attention of: _____ MDS / BD: _____

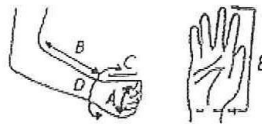
Measurement Legend (Please fill out per patient): Rep on site Facility to Rep Facility to CMR

** Please document in the nursing or therapy chart the diagnosis you note below.*

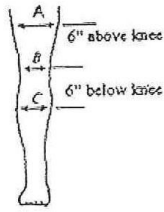
Elbow Dx: Elbow Contracture Mild Moderate Severe **PRODUCT**

	<p>A: Mid-Humerus Circumference (Left) _____ inches (Right) _____ Inches</p> <p>B: Proximal Forearm Circumference (Left) _____ inches (Right) _____ Inches</p> <p>C: Length, axilla to elbow center (Left) _____ inches (Right) _____ Inches</p> <p>D: Length, elbow center to styloid (Left) _____ inches (Right) _____ Inches</p>	
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Hand Dx: Wrist Drop Finger Contracture Wrist Contracture

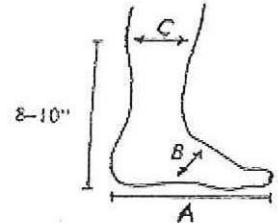
	<p>A: M / P Width (Left) _____ inches (Right) _____ Inches</p> <p>B: Forearm Length (Left) _____ inches (Right) _____ Inches</p> <p>C: Hand, Distal Phalanx to Wrist (Left) _____ inches (Right) _____ Inches</p> <p>D: Wrist Circumference (Left) _____ inches (Right) _____ Inches</p> <p>E: Hand Length (Left) _____ inches (Right) _____ Inches</p>	
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Knee Dx: Knee Contracture Mild Moderate Severe
 Transfer/Ambulatory { with KX sheet } Recumbent

 <p>Note: Measure 6" above/ below kneecap</p>	<p>A: Mid-Thigh Circumference (Left) _____ inches (Right) _____ Inches</p> <p>B: Kneecap Circumference (Left) _____ inches (Right) _____ Inches</p> <p>C: Mid-Calf Circumference (Left) _____ inches (Right) _____ Inches</p>	
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Ankle-Foot Dx:

<input type="checkbox"/> MULTIPODUS BOOT <input type="checkbox"/> Plantar Flexion Contracture <input type="checkbox"/> Degree of Contracture. _____ Right _____ Left <input type="checkbox"/> Plantar Fasciitis <input type="checkbox"/> Compromised Skin Integrity	<input type="checkbox"/> AFO {Plastic AFO} <input type="checkbox"/> Foot Drop <input type="checkbox"/> Ankle Instability <input type="checkbox"/> Acquired Ankle Deformity <input type="checkbox"/> Ambulatory <input type="checkbox"/> Other: _____	<input type="checkbox"/> AFO {Matrix, Curve, Toe off} <input type="checkbox"/> Foot Drop <input type="checkbox"/> CVA <input type="checkbox"/> Instability <input type="checkbox"/> Acquired Ankle Deformity <input type="checkbox"/> Knee weakness <input type="checkbox"/> Ambulatory <input type="checkbox"/> Liner for skin protection (Diabetic)
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 <p>(Special Instructions)</p>	<p>A: Heel to Toe Length (Left) _____ inches (Right) _____ Inches</p> <p>B: Mid-Foot Circumference (Left) _____ inches (Right) _____ Inches</p> <p>C: Mid-Calf Circumference (Left) _____ inches (Right) _____ Inches</p> <p>Shoe Size _____</p> <p><input type="checkbox"/> Heat Mold (Left) _____ degrees (Right) _____ degrees</p>	<p><u>NOTES</u></p>
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Please FAX this order with the patient face sheet and therapy evaluation to: (800) 603-3939