Assessment Form:
ComfySplints™ Hand Splints

ComfySplints
We Make The World Comfy

Patient Name:	HICN #
Facility:	
Address:	
Primary Diagnosis:	Secondary Dx:

Prognosis:	Good		Fair		Poor		
Mobility:	Ambulatory		Wheelchair Confined		Bed Confined		
Communication:	Makes Needs Know		Unable to Make Needs Known				
U.E. Sensation:	Intact		Moderately Impaired		Severely Impaired		
U.E. Active ROM:	WNL		Mildly Restricted		Severely Restricted		
U.E Passive ROM:	WNL		Mildly Restricted		Severely Restricted		

Diagnosis	Rt	Lt	Comments
Wrist Drop			
Wrist Contracture			
MP Contracture			
Finger Joint Contracture			
Elbow Contracture			
Ulnar / Radial Deviation			
Decreased Muscle Strength			
Decreased ADL Function			
Joint Pain			
Pressure Sores			
Hygiene Deficits			

Treatment Goals	
Prevent Fixed Contractures	
Support Flaccid Hand, Wrist and Elbow	
Manage Arthritic Joint Deformities	
Decrease Pain	
Increase U.E. Function	
Control Ulnar or Radial Deviation	
Improve Muscle Strength	
Improve ADL Function	
Increase Range of Motion	
Decrease Pressure of Motion	
Increase Hygiene	

Treatment Plan:			
	4-Strap Hand (4S-H)		Finger Extender (F)
	4-Strap Hand Thumb (4S-HT)		Goniometer Hand (GH)
	Adjustable Cone Hand (ACH)		Goniometer Hand Thumb (GHT)
	Air Hand (HA)		Hand-Wrist-Finger (H)
	Comfy Grip (CGrip)		Hand-Thumb (HT)
	Deviation Finger Extender (DF)		Hand Flex (H-Flex)
	Deviation Hand (DH)		Opposition HT (OPH)
	Deviation Hand Thumb (DHT)		Progressive RH (PRH)
	Rest Hand / Deviation Rest Hand (RH/DRH)		Spring Loaded Goniometer Hand (SGH)
	Deviation Opposition Hand Thumb (DOPH)		Spring Loaded Goniometer Hand Thumb (SGHT)
	Dorsal Hand (DORSH)		Soft-Roll Finger Extender (SRF)

Observe from 15 to 30 min. intervals. Then graduate to 1 to 2 hour intervals. Remove and check for pressure areas.

I certify active treatment of this patient. This equipment is part of my recommended treatment and is reasonable and medically necessary. The above information is true and accurate to the best of my knowledge.

O.T. / P.T. Signature: _____ Date: _____

Address: _____

Contact No.: _____ UPIN # _____