

# Assessment Form: ComfySplints™ Knee and AFO Splints



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

Prognosis:	Good	<input type="checkbox"/>	Fair	<input type="checkbox"/>	Poor	<input type="checkbox"/>
Mobility:	Ambulatory	<input type="checkbox"/>	Wheelchair Confined	<input type="checkbox"/>	Bed Confined	<input type="checkbox"/>
Communication:	Makes Needs Know	<input type="checkbox"/>	Unable to Make Needs Known	<input type="checkbox"/>		<input type="checkbox"/>
L.E. Sensation:	Intact	<input type="checkbox"/>	Moderately Impaired	<input type="checkbox"/>	Severely Impaired	<input type="checkbox"/>
L.E. Active ROM:	WNL	<input type="checkbox"/>	Mildly Restricted	<input type="checkbox"/>	Severely Restricted	<input type="checkbox"/>
L.E. Passive ROM:	WNL	<input type="checkbox"/>	Mildly Restricted	<input type="checkbox"/>	Severely Restricted	<input type="checkbox"/>

Diagnosis	Rt	Lt	Comments
Foot Drop-Plantar Flex	<input type="checkbox"/>	<input type="checkbox"/>	
Knee Contracture	<input type="checkbox"/>	<input type="checkbox"/>	
Hip Add/Abduction	<input type="checkbox"/>	<input type="checkbox"/>	
Post-Op Surgery	<input type="checkbox"/>	<input type="checkbox"/>	
Ankle Contracture	<input type="checkbox"/>	<input type="checkbox"/>	
Internal/External Rotation	<input type="checkbox"/>	<input type="checkbox"/>	
Decrease Muscle Strength	<input type="checkbox"/>	<input type="checkbox"/>	
Decrease ADL Function	<input type="checkbox"/>	<input type="checkbox"/>	
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Pressure Sores	<input type="checkbox"/>	<input type="checkbox"/>	
Hygiene Deficits	<input type="checkbox"/>	<input type="checkbox"/>	

Treatment Goals	
Prevent Fixed Contractures	<input type="checkbox"/>
Support Knee, Ankle & Foot	<input type="checkbox"/>
Manage Arthritic Joint Deformities	<input type="checkbox"/>
Decrease Pain	<input type="checkbox"/>
Increase L.E. Function	<input type="checkbox"/>
Control Hip Internal / External Rotation	<input type="checkbox"/>
Improve Muscle Strength	<input type="checkbox"/>
Improve ADL Function	<input type="checkbox"/>
Increase Range of Motion	<input type="checkbox"/>
Decrease Pressure Of Motion	<input type="checkbox"/>
Increase Hygiene	<input type="checkbox"/>

Treatment Plan:			
<input type="checkbox"/>	Knee Orthosis (K)	<input type="checkbox"/>	Ambulating Boot (ABoot)
<input type="checkbox"/>	Goniometer Knee (GK)	<input type="checkbox"/>	Comfy Boot (CBoot)
<input type="checkbox"/>	Spring Loaded Goniometer Knee (SGK)	<input type="checkbox"/>	Ambulating Boot with Strap (ABoot-Strap)
<input type="checkbox"/>	Locking Knee (LK)	<input type="checkbox"/>	Comfy Boot with Strap (CBoot-Strap)
<input type="checkbox"/>	Mechanical Hip & Knee Abductor (ABD)	<input type="checkbox"/>	Comfy Night Boot (NBoot)
<input type="checkbox"/>	Spring Ankle Foot (SAF)	<input type="checkbox"/>	

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.

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Contact No.: \_\_\_\_\_ UPIN # \_\_\_\_\_