Genco Grup

CRANIAL PROTECTIVE ORTHOSIS ORDER FORM

Patient's Name (PHI):________________________ Age in years _____Date of Cast/Scan_____
Facility Name_______________________________ Practitioner___________________________
Billing Address:______________________________Shipping Address_______________________
_______________________________________ _______________________________________
P.O. # _________________________________ Telephone:______________________________
Fax: _______________________ Shipping via 2nd Day Air or other _______________________
Email: ___________________________________ Date Needed:__________________________

Prerequisites for using a Cranial Protective Orthosis. Proceed with the order if each statement below applies to this patient.

- The prescription for this orthosis was written by the physician providing ongoing treatment for the condition that requires the cranial protective orthosis.
- The **C**ranial **P**rotective **O**rthosis will be applied over intact skin.
- I understand that the cast/scan and the order form must meet quality control standards as defined by Orthomerica protocols prior to beginning fabrication.

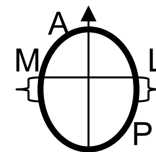
Type of model sent:

☐ Patient Cast Impression ☐ Patient Scan

The turnaround time for a Patient Cast Impression or Scan is 4 days after the date of the cast/scan and completed paperwork are received at Orthomerica.
NOTE: If being fit to an infant or a toddler, Cranial Protective Orthosis should be fit within 2 weeks of casting/scanning to ensure effective fit and function.

Patient Data

Measurements are taken over stockinet.
Caliper Measurement of Width (M-L) _____
Caliper Measurement of Length (A-P) ____
Head Circumference at eyebrows _______



Note: Follow standard measurement techniques to ensure that measurements are consistent and can be matched to patient measurements for identification purposes.

Comments: Indicate special clinical information such as diagnosis, surgical site or other instructions needed to fabricate the protective helmet (include photographs).

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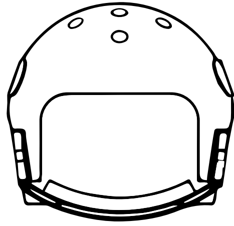
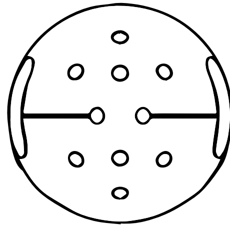
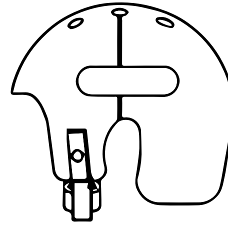
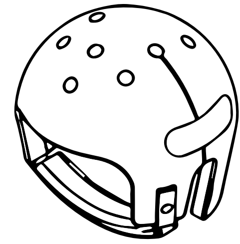
Protective Helmet

Note: Picture above is for illustraåon purposes only.

☐ **Full Helmet**

-- 3/16”- 1/4” Copoly Finished Shell

--1/2” Aliplast Liner

--Velcro Side Strap

--Dacron Chinstrap

Note: Plastic thickness will vary depending on head size.

Defaults are listed below in bold text.

☐ **Do not modify the cast except to achieve purchase.**

☐ Add a buildup over a specific area as marked on the cast or scan information.
Describe the exact location of the desired buildup of the area to protect.
Note: (If any of the conditions below apply, forward photographs with your order).
☐Shunt ☐Hematoma ☐Swelling ☐Incision Site ☐Other Specify:____________

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Trim Lines: ☐ **Default (shown above)** ☐Long trim lines

Liner/Pads: ☐ **Default (shown above)** ½” Aliplast Liner

☐ (3) 1/8” + (1) 1/4" Aliplast Liners

Transfer: ☐ **None** ☐ Design _________________

Strap transfer ☐ **None** ☐ Match helmet (Available for Velcro side strap only)

Finish: ☐ **Trimmed and finished**

Chinstrap: ☐ **Attached** ☐ Do not attach

Positive mold:☐**No mold returned** ☐Return mold

Patient cast impression:☐**No return** ☐Return mold

Photographs: ☐ **Do not return** ☐Return with helmet ☐ No photographs provided

Other information:____