



HELIX PLUS AFO PRESCRIPTION FORM

ADMINISTRATIVE DETAILS

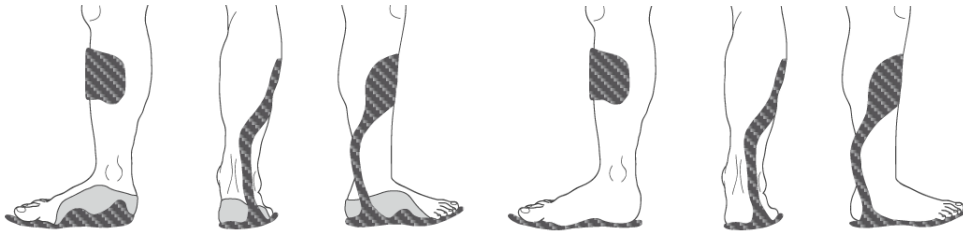
Date ___/___/___ Facility _____ PO No. _____
Orthotist E-mail _____ Appointment Date ___/___/___

END USER DETAILS

Client Reference _____ Left Right
End User Relevant Medical History _____
Weight _____ Height _____

BIOMECHANICAL OBJECTIVES

- Control Dorsiflexion Weakness
- Control Ankle Valgus Instability
- Other _____
- Control Plantar Flexion weakness
- Resist Knee Hyperextension in Stance
- Control Ankle Varus Instability
- Resist Knee Flexion in Stance



- Helix Plus with Cupped Footplate (DEFAULT)
- Helix Plus with Flat Footplate

CAST

- Negative Cast is correct
 - Negative Cast imperfect - Describe
- _____
- _____
- _____

PITCH MEASURE



Rear foot _____ MM
Forefoot _____ MM

SHOE SIZING

- Shoe Size _____
- Match Template traced on form
 - Shoe provided to match

STRAP OPTIONS

- Velfoam wrap with crocodile clip (DEFAULT) Calf
- Leather Returning Calf
- Other _____
- Include floating pads on straps
- Include a spare set of straps

NOTES
