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DAFO® 3

Reset Form

PATIENT

Last Name:	
First Name:	
DOB:	◯ Bilateral ◯ Left ◯ Right

PRACTITIONER

Name:	Title:
Email:	
Phone:	

BILLING

■ **RUSH ORDER($)**

Name:	
Address:	
City:	State: Zip:
PO#:	

SHIPPING

■ Same as Billing

Name:	
Facility:	
Address:	
City:	State: Zip:

NOTE: If no options are selected, you will receive the ***DAFO Standard*** (see illustration).

POSITION OF FUNCTION

BRACE HEIGHT:

◯ ***Standard*** ◯ Specify: _____ mm

BRACE LENGTH:

◯ ***Standard*** ◯ Specify: _____ mm

ANKLE ALIGNMENT:

◯ 3° DF ◯ _____ ° DF ◯ _____ ° PF ◯ Do Not Correct

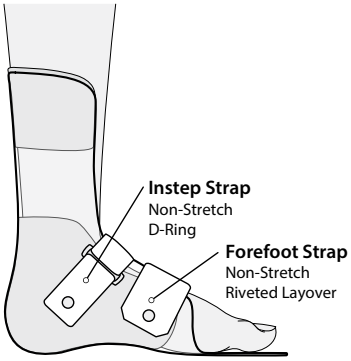
HINDFOOT ALIGNMENT:

◯ Vertical ◯ Correct Halfway ◯ Do Not Correct

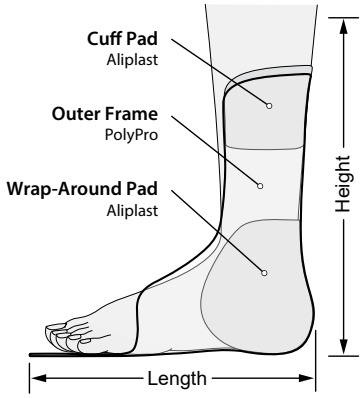
FOREFOOT ALIGNMENT:

◯ Neutral ◯ Varus: _____ mm ◯ Valgus: _____ mm
◯ Do Not Correct

MEDIAL (Left)



LATERAL (Left)



STABILITY

STABILIZATION:

◯ ***None*** ◯ Heel ◯ Midfoot ◯ Heel-to-Midfoot ◯ Heel-to-Toe

NON-SKID:

◯ ***None*** ◯ Vibram

CONTROL

LATERAL MET. HEAD *(TRIMLINE)*:

◯ ***At Met. Head*** ◯ Distal ◯ Proximal ◯ Long Containment

MEDIAL MET. HEAD *(TRIMLINE)*:

◯ ***At Met. Head*** ◯ Distal ◯ Proximal ◯ Long Containment

SOFT CONTAINMENT:

◯ ***None*** ◯ Lateral ◯ Medial ◯ Lateral & Medial

TOE RISE:

◯ ***Toe Rise*** ◯ Toe Rise w/ Abduction Strap

COMFORT

TALUS & NAVICULAR PADDING:

◯ ***None*** ◯ Add PPT

COSMETIC

ALIPLAST PAD COLOR:

◯ ***White*** ◯ Specify: _____

STRAP COLOR:

◯ ***White*** ◯ Specify: _____

TRANSFER:

◯ ***None*** ◯ Specify: _____

ADDITIONAL INSTRUCTIONS

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