Evoke™ OA knee brace — Order Form

PATIENT INFORMATION

Last name: _____

First name: _____

Age: _____ Height: _____ ft _____ in. Weight: _____ lbs. Sex: _____

Email: _____

Phone: _____

Diagnosis: _____

OTHER INFORMATION

Scanned by (professional): _____

Phone (professional): _____ Ext.: _____

Email (professional): _____

Date brace required by customer: _____

PO #: _____ Customer #: _____

SHIPPING INFORMATION

☐ Ground (6-12 days) ☐ Rush (extra $ - please call)

BILLING ADDRESS

Contact: _____

Company: _____

Address: _____

City: _____

State/Prov.: _____ ZIP/P.C.: _____

SHIPPING ADDRESS (if different)

Contact: _____

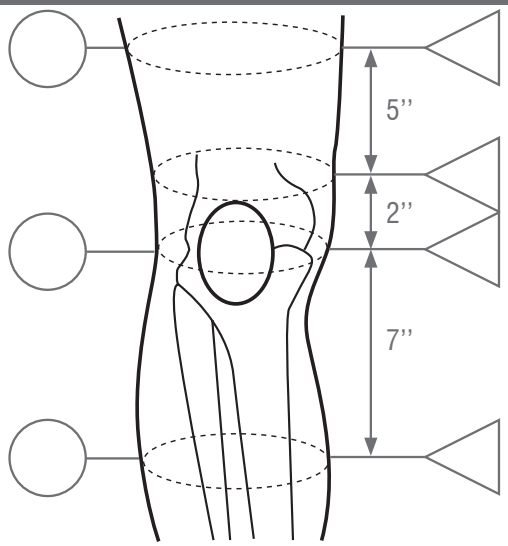
Company: _____

Address: _____

City: _____

State/Prov.: _____ ZIP/P.C.: _____

FORM MEASUREMENTS



MEASUREMENT TYPE

Scanned with sleeve: ☐ Yes ☐ No

KNEE

☐ Right ☐ Left **OA Condition:** ☐ Lateral ☐ Medial

☐ Prominent tibial crest

☐ Prominent fibular head ☐ Condyles sensitive to pressure

TYPE OF DAILY ACTIVITY

☐ Leisure ☐ Light sport ☐ Sport/physical work

ASSESSMENT

☐ Varus ☐ Hyperextension ☐ Surgery: _____

☐ Valgus ☐ Hyperlaxity ☐ Flexum ☐ Other: _____

COLORS AVAILABLE

Femoral part		Tibial part
Black	Red	Black
White	Blue	White

ACCESSORIES

(Additional fees may apply)

Additional adjustable strap:

☐ Tibial Anterior

☐ Tibial Posterior

Extra padding:

☐ Supra condyle

☐ Lateral condyle

☐ Medial condyle

UNLOADING SPECIFICATIONS (default correction is 5°)

Total correction of unloading: _____°

SPECIAL NOTES

☐ Request contact prior production

_____

_____

_____

Contact: 514-978-3668 | **www.osskin.com**

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