Evoke™ OA knee brace — Order Form

ORDER INFORMATION

Patient ID*: _____

Age*: _____ Sex*: _____

Height*: _____ Weight*: _____ lbs.

Diagnosis: _____

_____

OTHER INFORMATION

Scanned by (professional)*: _____

Phone (professional)*: _____ Ext.: _____

Email (professional)*: _____

Date brace required by customer: _____

PO #*: _____

BILLING ADDRESS

Contact*: _____

Company*: _____

Address*: _____

City*: _____

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

SHIPPING ADDRESS (if different)

Contact*: _____

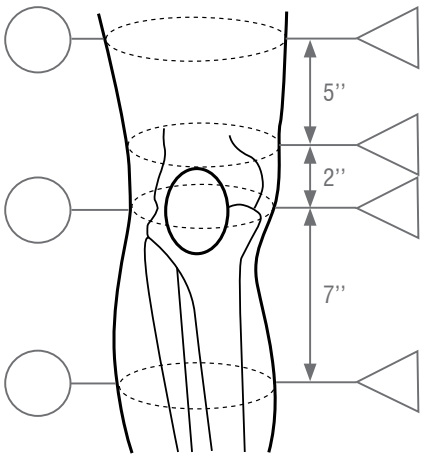
Company*: _____

Address*: _____

City*: _____

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

FORM MEASUREMENTS*



Measurements are in*: ◯ Inch ◯ mm ◯ cm

SCANNED OBJECT*

Scan of Leg: ◯ with sleeve ◯ without sleeve

◯ Scan of a Cast

KNEE*

☐ Right ☐ Left

OA Condition*: ◯ Lateral ◯ Medial ◯ Neutral

Ligament condition: ☐ ACL ☐ PCL ☐ MCL ☐ LCL

TYPE OF DAILY ACTIVITY*

◯ Leisure ◯ Light sport ◯ Sport/physical work

ASSESSMENT*

◯ Varus ☐ Hyperextension ☐ Surgery: _____

◯ Valgus ☐ Hyperlaxity ☐ Flexum ☐ Other: _____

COLORS AVAILABLE

Femoral part*

◯ Black ◯ Red

◯ Blue ◯ Gray

Tibial part*

◯ Black ◯ Red

◯ Blue ◯ Gray

OPTION

Tibial straps*:

◯ 2 Posterior Straps (default)

◯ 1 Posterior Strap (optional)

☐ Anterior Strap (optional)

Condyle pad*:

◯ 5mm (default)

◯ 7mm (optional)

UNLOADING SPECIFICATIONS*

◯ Medial unloading ◯ Lateral unloading ◯ Neutral

Total (degrees): _____ °

SPECIAL NOTES

Contact: production@osskin.com | 1-888-308-7978 | www.osskin.com

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