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: _____

HD PO #*: (required for manufacturing): _____

BILLING ADDRESS

Contact*: _____

Company*: _____

Address*: _____

City*: _____

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

SHIPPING ADDRESS (if different)

Contact*: _____

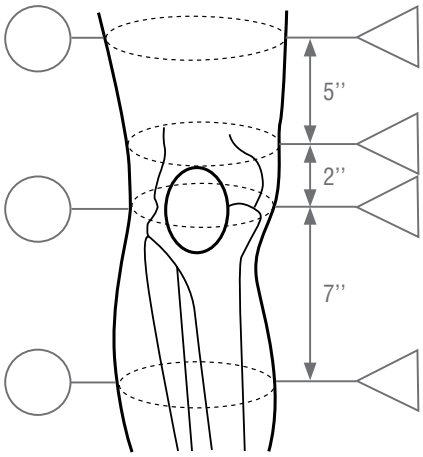
Company*: _____

Address*: _____

City*: _____

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

FORM MEASUREMENTS*



Measurements are in*: ☐ Inch ☐ mm ☐ cm

MEASUREMENT TYPE*

Scanned with sleeve: ☐ Yes ☐ No

KNEE*

☐ Right ☐ Left

OA Condition*: ☐ Lateral ☐ Medial

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, Orange

White, Blue

Tibial part*

Black

White

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: 1-888-308-7978 | **www.osskin.com**

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