Assessment Form:
Comfyprene Knee Splints

ComfySplints
We Make The World Comfy

Patient Name:		*HICN #*	
Facility:			
Address:			
Primary Diagnosis:		*Secondary Dx:*	

Prognosis:	Good		Fair		Poor	
Mobility:	Ambulatory		Wheelchair Confined		Bed Confined	
Communication:	Makes Needs Know		Unable to Make Needs Known			
L.E. Sensation:	Intact		Moderately Impaired		Severely Impaired	
L.E. Active ROM:	WNL		Mildly Restricted		Severely Restricted	
L.E Passive ROM:	WNL		Mildly Restricted		Severely Restricted	

Diagnosis	Rt	Lt	Comments
Foot Drop-Plantar Flex			
Knee Contracture			
Hip Add/Abduction			
Post-Op Surgery			
Ankle Contracture			
Internal/External Rotation			
Decrease Muscle Strength			
Decrease ADL Function			
Joint Paint			
Pressure Sores			
Hygiene Deficits			

Treatment Goals	
Prevent Fixed Contractures	
Support Knee, Ankle & Foot	
Manage Arthritic Joint Deformities	
Decrease Pain	
Increase L.E. Function	
Control Hip Internal / External Rotation	
Improve Muscle Strength	
Improve ADL Function	
Increase Range of Motion	
Decrease Pressure Of Motion	
Increase Hygiene	

Treatment Plan:			
	Knee Orthosis (K-CP)		
	Goniometer Knee (KG-CP)		
	Spring Loaded Goniometer Knee (KSG-CP)		

Observe from 15 to 30 min. intervals. Then graduate to 1 to 2 hour intervals. Remove and check for pressure areas.

I certify active treatment of this patient. This equipment is part of my recommended treatment and is reasonable and medically necessary. The above information is true and accurate to the best of my knowledge.

Physicians Signature: _____ *Date:* _____

Address: _____

Contact No.: _____ *UPIN #* _____