FITTER ACKNOWLEDGMENT FORM- SPINE

Please attach product barcode sticker
-OR-
write description here

PATIENT INFORMATION

Name (Last, First): _____

DOB: _____/_____/_____

Service location: (___) Home (___) HCP's Office (___) PSC (___) Hospital: _____ (___) Other: _____

Patiently currently resides at: (___) Home (___) SNF (___) Other: _____

PATIENT ASSESSMENT

(___) Kyphosis
(___) Scoliosis
(___) Pendulous Abdomen
(___) Pectus Abnormality
(___) Port
(___) Colostomy
(___) Other: _____

MEASUREMENT(S)

(___) Waist: _____
(___) Hip: _____
(___) Length: _____

Explain **WHY** adjustment more than the minimal self -adjustments is required:

_____

_____

_____

ADJUSTMENT(S)

_____ USE HEATING ELEMENT TO:
(___) Flare anterior panel
(___) Flare posterior panel
(___) Other: _____

_____ MANUAL ADJUSTMENT TO:

(___) **BEND**:	◯ Lateral panel	◯ Other: _____		
(___) **MOLD**:	◯ Anterior panel	◯ Posterior panel	◯ Other: _____	
(___) **SHAPE**:	◯ Lateral panel	◯ Other: _____		
(___) **CONTOUR**:	◯ Lateral panel	◯ Anterior panel	◯ Posterior panel	◯ Thoracic Bar
(___) **TRIM**:	◯ Anterior panel	◯ Posterior panel	◯ Other: _____	
(___) **REASSEMBLE**:	◯ Removed/Trimmed	◯ Belt/Pectoral Pad		
	◯ From frame to:	◯ Accommodate port	◯ Accommodate pectus abnormality	

(___) **OTHER**: _____

(___) **ADD CUSTOM PADS**: _____

Equipment Used: _____

Specialized adjustment made to orthosis required patient education: _____

_____

_____

NOTE TO CLINICIAN- SERVICES/ACTIONS

Ensure you have addressed the following during your interaction with this patient: a) Assess the orthosis for structural safety and ensure that the manufacturer guidelines are followed prior to fitting (e.g., patient's weight limits, ensuring closures work properly, etc.) and ensure the orthosis is fit properly; b) Provide education, training, and/or written instructions on the use and function of the orthosis, key components and features of the orthosis, application and removal of the orthosis, and care and cleaning of the orthosis; c) Provide written instructions for obtaining needed follow up services and instruct the patient to communicate to the staff any service/product problems; and d) Confirm warranty information was provided to the patient as part of the POD.

By my signature below, I affirm that the information above is true and accurate, and that I personally conducted the assessment and custom fitting (if applicable) on the date noted below:

Clinician/Fitter Signature: _____ Date: _____/_____/_____ □ Check if Prescribing Clinician

Name (Print): _____ Title/Credentials: _____

Orthotist/Prescribing Clinician Signature (if applicable): _____ Date: _____/_____/_____

Name (Print): _____ Title/Credentials: _____