ottobock.

C-Brace Evaluation Form A

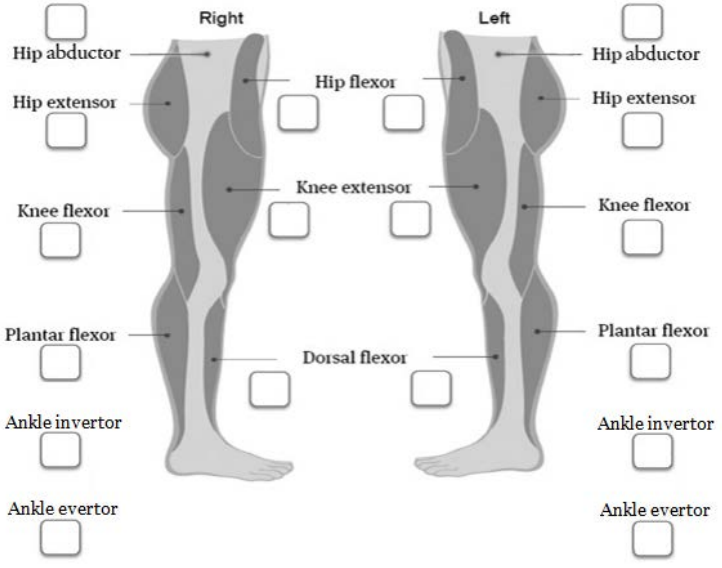
Facility		Orthotist	
Address		NPI	
Suite/Unit		Phone	
City, State, Zip		Fax	

1. Patient Demographics

Name			Date of Birth / Age
Weight	Height	Affected Side(s) ❑ L ❑ R	Gender ❑ M ❑ F
Primary Diagnosis			Occupation
Clinical Presentation			
Medical Insurance:	Company		Plan

2. Manual Muscle Test

Muscle Strength Assessment		
5	Normal	Movement with normal strength.
4	Good	Movement against low to medium resistance possible.
3	Weak	Movement against gravity possible.
2	Very Weak	Distinct Muscle Tension. Movement is possible if gravity effect is eliminated.
1	Trace	Visible and palpable muscle contraction with no motoric effect.
0	None	No visible and/or palpable muscle contraction



3. Passive Range of Motion Assessment – Using Neutral Zero Method (indicate in degrees)

The Neutral Zero Method documents the range of motion (ROM) as well as fixed/reducible contractures of a joint. The "zero" stands for the neutral position of the joint between the two movement directions in the plane of movement, e.g. for full extension (180°) of the knee in the sagittal plane (flexion-extension). The normal ROM of the knee joint in the sagittal plane is therefore documented "flexion-extension 140°/0°/0°, representing 140° of flexion, full extension of 180° (first 0) and no hyperextension (second 0). The ROM of a knee with a slight hyperextension of 5° is documented "flexion-extension 140°/0°/5". For a knee with normal flexion and a fixed flexion contracture of 10°, the ROM and the contracture is documented "flexion-extension 140°/10°/0". If the contracture can be reduced by 5°, it is documented "flexion-extension 140°/10°/5".

❑ All WNL

	Normal	**Right Side**	**Left Side**
Hip Flexion-Extension	140°/0°/30°	❑ WNL ____°/____°/____°	❑ WNL ____°/____°/____°
Hip Abduction-Adduction	45°/0°/30°	❑ WNL ____°/____°/____°	❑ WNL ____°/____°/____°
Hip Internal-External Rotation (Knee and Hip in 90° flexion)	40°/0°/45°	❑ WNL ____°/____°/____°	❑ WNL ____°/____°/____°
Knee Flexion-Extension	140°/0°/0°	❑ WNL ____°/____°/____°	❑ WNL ____°/____°/____°
Ankle Dorsiflexion-Plantar Flexion	30°/0°/50°	❑ WNL ____°/____°/____°	❑ WNL ____°/____°/____°
Foot Inversion-Eversion	35°/0°/25°	❑ WNL ____°/____°/____°	❑ WNL ____°/____°/____°

4. Alignment (only indicate, in degrees, any axis that deviates from anatomical neutral)

❑ No deviations

	Right Side			**Left Side**		
		Uncorrected Angle	Reduced Angle		Uncorrected Angle	Reduced Angle
Hip	❑ No deviations ❑ Vara ❑ Valga	_____°	_____°	❑ No deviations ❑ Vara ❑ Valga	_____°	_____°
Knee	❑ No deviations ❑ Varum ❑ Valgum ❑ Recurvatum	_____°	_____°	❑ No deviations ❑ Varum ❑ Valgum ❑ Recurvatum	_____°	_____°
Ankle	❑ No deviations ❑ Varus ❑ Valgus	_____°	_____°	❑ No deviations ❑ Varus ❑ Valgus	_____°	_____°

Patient Name Date of Birth

5. Joint Replacement

Right Side (check all that apply)	**Left Side** (check all that apply)
❑ Hip	❑ Hip
❑ Knee	❑ Knee
❑ Ankle	❑ Ankle

If applicable, how might the joint replacement affect the patient's ability to ambulate with the new device(s)?

6. Deformities

Leg length difference: _____ cm

Foot Deformity Right Side		Foot Deformity Left Side	
❑ No ❑ Yes	If yes, describe	❑ No ❑ Yes	If yes, describe

7. Patient Interview

Is the patient using a powered wheelchair?	❑ yes ❑ no
Is the patient currently participating in physical therapy?	❑ yes ❑ no
When was the last time the patient received physical therapy?	
Is patient willing to participate in Physical Therapy to the extent needed to use all of the functionality of the system (including: the time, transportation, financial resources)?	❑ yes ❑ no
Is patient aware that service must be performed every two years and he/she will be without the system for one week at that time?	❑ yes ❑ no
Was patient injured at work?	❑ yes ❑ no
Has patient returned to work?	❑ yes ❑ no

Orthotist Signature & Credential

Orthotist Printed Name

Date Signed

Patient Name Date of Birth