Juno pediatric knee brace

Order Form

ORDER INFORMATION

Patient ID*: _____

Age*: _____ Sex*: _____

Height*: ____ ft ____ in. 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*: _____

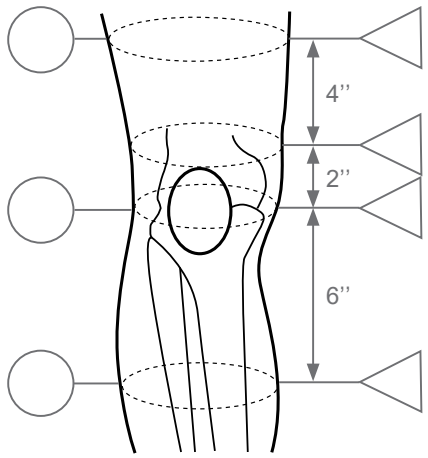
Company*: _____

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

Affected ligament: ☐ ACL ☐ MCL ☐ LCL

☐ Knee Instability

Osteochondritis Dissecans: ☐

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*:

☐ Anterior Strap (optional)

Condyle pad*:

○ 5mm (default)

○ 7mm (optional)

UNLOADING * *(applies only for Osteochondritis Dissecans)*

○ Medial unloading ○ Lateral unloading ○ Neutral

Total (degrees): _____ °

SPECIAL NOTES

_____

_____

_____

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

OssKin