THUASNE

SpryStep® AFO
Product Return Questionnaire

Ordering Clinician

☐ CPO ☐ CO ☐ CP ☐ Other: _____

Name: _____

Email: _____ Phone: _____

Billing & Shipping

PO#:

Billing Account#: _____

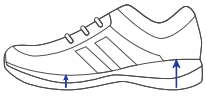
Shipping Account#: _____

Shipping Address: _____

City: _____ State: _____ Zip: _____

Your Patient Profile

Weight ☐ *lbs* ☐ *kgs* _____ Height ☐ *in* ☐ *cm* _____ Age _____



Shoe size _____

Effective heel height of shoe ☐ *in* ☐ *cm* _____

Occupation _____

Patient's diagnosis _____

Patient Range of Motion *(ROM)*, Manual Muscle Test *(MRC)* and Modified Ashworth Scale *(MAS)*

Foot Posture Index *(customer will select one)*

☐ -2 ☐ -1 ☐ 0 ☐ 1 ☐ 2

a. Hip ROM: _____° extension to _____° flexion

b. Knee ROM: _____° extension to _____° flexion

c. Ankle ROM, with knee extended

Dorsi-Flexion _____°

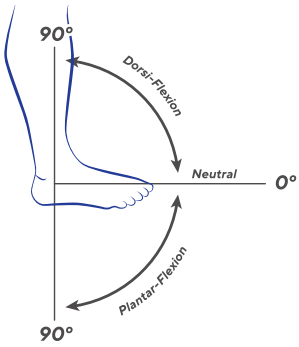
Plantar-Flexion _____°

d. Plantarflexion contracture

☐ Yes _____° ☐ No

e. Knee Flexion contacture

☐ Yes _____° ☐ No



Hip Flexion

MMT _____

MAS _____

Hip Extension

MMT _____

MAS _____

Knee Extension

MMT _____

MAS _____

Knee Flexion

MMT _____

MAS _____

Ankle Dorsiflexion

MMT _____

MAS _____

Ankle Plantarflexion

MMT _____

MAS _____

Patient Activity Level *(choose all that apply)*

☐ Limited ambulator: *sits to stands and transfers*
☐ Household ambulator: *level surfaces with walking aids*
☐ Limited community ambulator: *level surfaces with walking aids*
☐ Active community ambulator: *mild inclines and declines with or without walking aids*
☐ Independent ambulator: *varied cadence, uneven surfaces and no walking aids*
☐ Active ambulator: *walking, running, some athletic activity*

Biomechanical Objectives *(choose all that apply)*

☐ Resist Knee Hyperextension in Stance
☐ Resist Knee Flexion in Stance
☐ Knee Valgus Control
☐ Knee Varus Control
☐ Control Ankle Varus Instability
☐ Posterior/Anterior Knee Drawer Control
☐ Control Dorsiflexion Weakness
☐ Control Plantar Flexion weakness
☐ Control Ankle Valgus Instability

Use of walking aids?

☐ Yes ☐ No

Fitting Analysis

Please provide an objective analysis of the fit using the fitted device as reference, including location (anatomical references) and value (by how much). Pictures are helpful to assist with the analysis.

Foot ☐ Too Large ☐ Too Tight

_____

please give value of how much and where (anatomical references)

Calf Band ☐ Too Large ☐ Too Tight

_____

please give value of how much and where (anatomical references)

Footwear and static alignment *(bench alignment)*

Does the HH of the patients shoe today match the order form?

☐ Yes ☐ No

Was any extrinsic wedging used?

☐ Yes _____ ☐ No

Gait Observations

Describe how the brace walks using the four rockers of gait. Videos are recommended to assist with the analysis.

Too stiff? _____

Describe gait observations seen

Too flexible? _____

Describe gait observations seen

Composite Material Delamination

This is often the end result of a device that is not controlling the patient optimally. Please ensure as much information is provided in the previous sections. Having the device returned is required for full composite analysis.

Where did it occur?

☐ Strut
☐ Strut / footplate junction
☐ Footplate
☐ Pre-tibial shell
☐ other _____

THUASNE

SpryStep® AFO

Product Return Questionnaire

How long was the device functioning before failure?

_____

Apart from standing and walking, what other activities did the patient participate in whilst wearing the device?

_____

How did the Failure occur?

- ☐ Delamination over time
- ☐ complete fracture

Configuration

- ☐ SpryStep® Vector
- ☐ SpryStep® Vector with Pre-Tibial Shell
- ☐ SpryStep® Vector with Coronal Extension
- ☐ SpryStep® Vector with Pre-Tibial Shell and Coronal Extension
- ☐ SpryStep® Flex, Contoured Footplate
- ☐ SpryStep® Flex, Molded inner boot
- ☐ SpryStep® Original, Contoured Footplate
- ☐ SpryStep® Original, Molded inner boot
- ☐ SpryStep® Plus, Contoured Footplate
- ☐ SpryStep® Plus, Molded inner boot

Brace side _____

Please send pictures and/or video of the failure and any labels on the brace.