Bio-Mechanical Composites

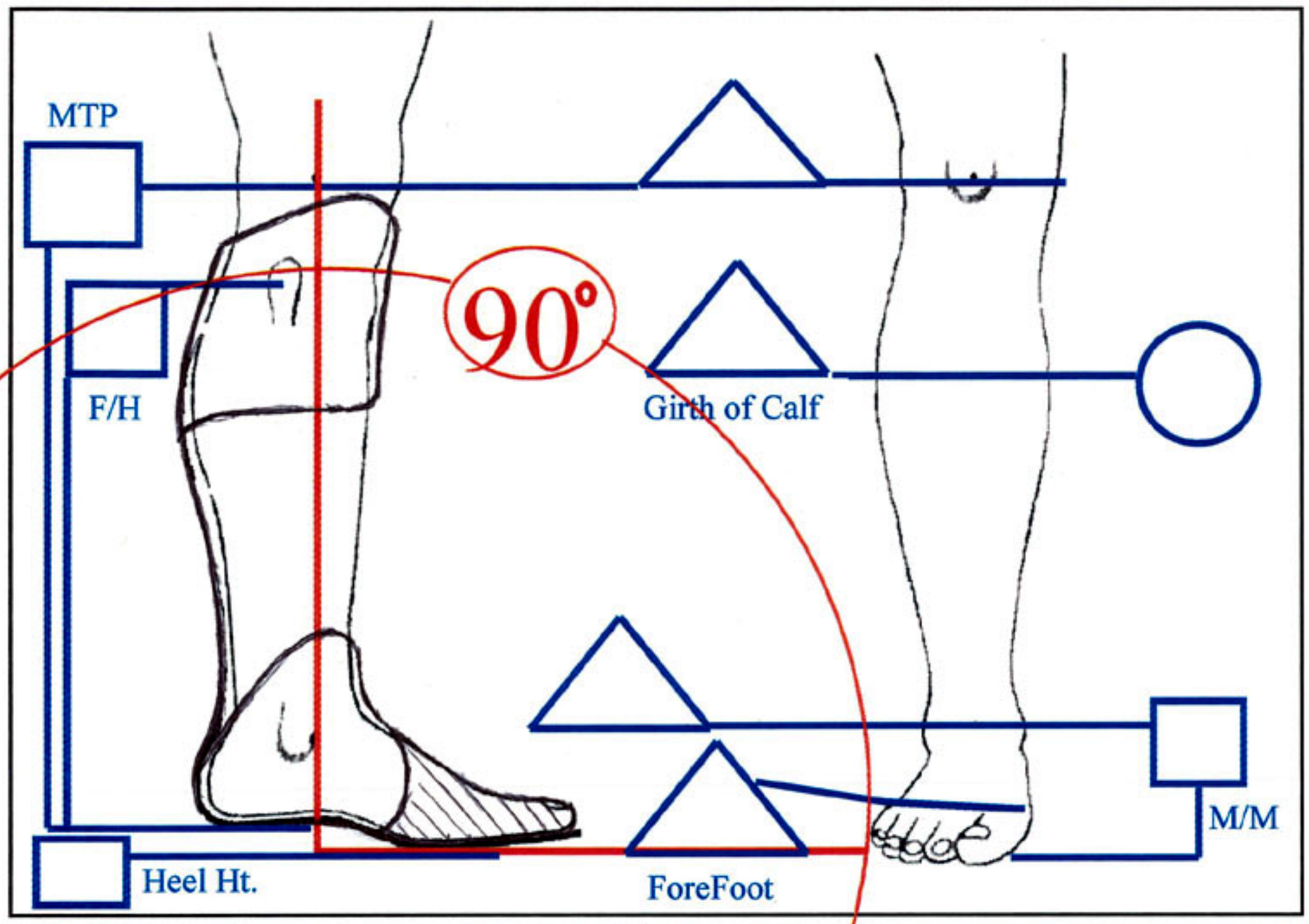
2505 McKinley Ave — Des Moines, IA 50321 — (515) 554-6132

Patient Name: _____

Date:_____ Right / Left

Dynamic Response
Partial Foot Prosthesis

Facility Name:_____
Address:_____
City/State/Zip:_____
Phone:_____



_____

Shoe Size

It is beneficial if the Sock liner insert from the patients shoe or the entire shoe is sent with the Cast.

_____

Foot Length
(Opposite Foot)

Posterior Spring

Moderate *Firm*

☐ Valgus Control
☐ Varus Control

Note:

_____
_____
_____
_____

NOTE:

Patients must be casted in a corrected position.

Maintaining the desired position of the knee joint above the ankle, Positioning the hind-foot in a neutral position with a functional range of motion and maintaining the Valgus/Varus position desired from the orthosis.

SUPINATION OF THE FORE_FOOT *may be necessary in the cast to maintain*

Lamination

☐ White ☐ Black

Sleeve:_____

Doctor: _____ Practitioner: _____

Diagnosis: _____

Suggested Billing Codes

- ☐ L5020 - Partial Foot, Tibial Tubercle Height, Toe Filler
- ☐ L5976 - All Lower Ext. Prosthesis, Energy Storing Foot
- ☐ L5629 - Add. To Lower Ext., BK Acrylic Socket
- ☐ L5661 - Add. To Lower Ext., Socket Insert, Multi-Durometer
- ☐ L5637 - Add. To Lower Ext., BK, Total Contact
- ☐ L5940 - Add. BK, Ultra-Light Weight Material

Authorization

_____

Lab Tracking

In ___/___/___
Tech _____
Mods ___/___/___
Lam 1 ___/___/___
Lam 2 ___/___/___
Out ___/___/___

Code

_____