True Friends
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Office Use Only
Session_____
Cabin_____
Cabin Copy_____
Nurse Copy_____

Orthopedic Appliances Questionnaire
(Splints, Braces, Prostheses)

To avoid service interruptions, we require this form to be on file before attending any True Friends program. Please plan to spend time with direct care staff and nurses to demonstrate the use of the appliance. Please provide Physical Therapy help sheets, pictures for placement or any other supporting documents that you may have to help our staff.

Name:_____ Dates Attending: _____

Please indicate type of appliance used: _____

To what body part is appliance applied? _____

*** Please clearly mark LEFT and RIGHT on the appliance, prior to arrival to this program. ***

What is worn under the appliance? _____

What special skin care is required? _____

Please indicate the schedule for use of the appliance: time on:_____ time off: _____

Appliance may be taken off for the following reasons:_____

Is appliance to be: (check any that apply) off during nap /rest hour?_____off for bathing/swimming?_____

If redness or skin break-down occur under the appliance, can it be left off for a period of time? _____
If so, how long? _____

Please use the space below for any additional information:

_____
_____
_____
_____
_____

_____
Name of Person Completing Form | Relationship to Participant | Phone | Date