
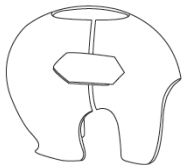
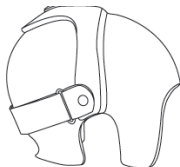

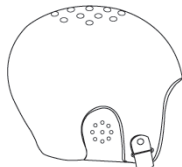


Orthomerica's Cranial Remolding Orthosis Order Form page 2 of 2

STARband® and STARlight™ Side Opening		STARband® and STARlight™ Bi-Valved		Clarren™ (helmet)		
 <input type="checkbox"/> STARband®		 <input type="checkbox"/> STARlight™		 <input type="checkbox"/> STARband®	 <input type="checkbox"/> STARlight™	 <input type="checkbox"/> Clarren™
<ul style="list-style-type: none"> • 5/32" Copolymer shell • 1/2" Pelite Liner • Stop Gap Foam Insert • Velcro® Closure 	<ul style="list-style-type: none"> • 1/4" Surlyn • Pelite Pads • Velcro® Closure 	<ul style="list-style-type: none"> • 5/32" Copolymer shell • 1/2" Pelite Liner • Velcro® Closure 	<ul style="list-style-type: none"> • 1/4" Surlyn • Pelite Pads • Velcro® Closure 	<ul style="list-style-type: none"> • 1/4" Polypropylene shell • 1/8" Aliplast Liner • Chinstrap 		

Defaults are Listed Below in Bold.

Modification: (Check only one)

- Correct asymmetry; Correct proportion up to the projected circumferential head growth**
- Full Correction of asymmetry, proportion, and cranial vault height asymmetry
- Correct asymmetry only
- Post-Op (suture involved/procedure used): _____

Post-Op (only) Cephalic Ratio: Correct to _____% No change

Primary Asymmetry Modification: **Posterior** Anterior

Neck Modification: **Defined Sub-Occipital Groove** Neck Smoothed and Left "As Is"

Trim Lines: **Default (As Shown Above)** Long Trim Lines Default w/Small Ears Provided by Practitioner (Pre-Modified Casts Only)

Side Opening: **Side Opposite Posterior Flattening** Left Right

Top Opening: (Check Only One) **Determined by Orthomerica Based On Head Shape** Oval Shape D-Trim

Optional Holding Caps: Anterior Right Anterior Left Posterior Right Posterior Left

Liner/Pads: **Default (As Shown Above)** 2 1/4" Aliplast Layers

Transfer: **None** Design (STARband & Clarren Only): _____

Strap Transfer: **None** Match Band

Finish: **Trimmed and Finished** Blank on Mold Blank on Mold and Split

Chafe Attachment: **Anterior to Opening** Posterior to Opening Do Not Attach

Positive Mold: **No Mold Returned** Return Modified Mold Return Unmodified Mold

Negative Cast Impression: **No Impression Returned** Return Modified Return Unmodified

Photographs: Do Not Return Return with Band No Photographs Provided

Other Information: _____

**ATTACH A PHOTOGRAPH OF THE ANTERIOR AND POSTERIOR VIEW OF THE BABY IN THE CAST.
Please ship both pages of the order form and any clinical photographs with the cast impressions to:**

**Orthomerica Products, Inc.
Custom Cranial Department
6333 North Orange Blossom Trail
Orlando, Florida 32810**

Contact Orthomerica Cranial Customer Service at 1-877-737-8444 with any questions.

Orthomerica's Cranial Remolding Orthosis Order Form

page 1 of 2

PRACTITIONERS MUST COMPLETE AN ORTHOMERICA CRANIAL REMOLDING COURSE PRIOR TO SENDING AN IMPRESSION FOR A CRANIAL REMOLDING ORTHOSIS

Infant's Name : _____ Corrected Age in Months: _____ Date of Cast (mandatory): _____

Facility Name: _____ Practitioner: _____

Billing Address: _____ Shipping Address: _____

P.O. # _____ Telephone: _____

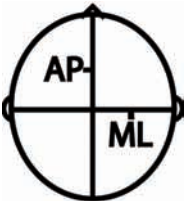
Fax: _____ Shipping Via 2nd-day Air or Other: _____

Email: _____ Date Needed: _____

Type of model sent: Unmodified Cast Impression Positive Unmodified Mold
 Modified Cast Impression Positive Modified Mold

The turnaround time for an unmodified cast impression is 4 days and 3 days for modified cast impressions after the date the cast and completed paperwork are received at Orthomerica. Headbands must be fit within 14 days of casting to ensure effective fit and function.

The cast and the order information must meet quality control standards as defined by Orthomerica protocol prior to beginning fabrication. Practitioners will be contacted regarding issues with the cast impression, measurements, or paperwork.

	Patient Data (Mandatory)	FOR MODIFIED MOLDS ONLY	
	Measurements of Baby's Head over Stockinet:	Positive Unmodified Mold	Positive Modified Mold
Caliper Measurement of Width (ML)	_____	_____	_____
Caliper Measurement of Length (AP)	_____	_____	_____
Head Circumference (above eyebrows and ears)	_____	_____	_____

Note: Take each measurement three times to ensure accuracy. Inaccurate measurements may cause your cast to be rejected. Follow the measurement techniques in the Practitioner Instructions to ensure that measurements are consistent and will match Orthomerica's measurements.

Check any boxes that apply to the head shape

- Occipital Area: Right Flattening > Left Left Flattening > Right Central Flattening
- Parietal Area: Right Flattening > Left Left Flattening > Right Bilateral Flattening
- Frontal Area: Right Flattening > Left Left Flattening > Right Bilateral Flattening
- Ear Alignment: Right Anterior Shift Left Anterior Shift No Ear Shift

Note: the > symbol indicates 'greater than'

Diagnosis: _____

Comments (indicate torticollis or other special clinical information here): _____

ATTACH A PHOTOGRAPH OF THE ANTERIOR AND POSTERIOR VIEW OF THE BABY IN THE CAST. Please ship both pages of the order form and any clinical photographs with the cast impressions.