CRANIAL CUSTOMER FEEDBACK FORM

CQR/RA—domestic

Please complete in full as appropriate for the complaint or issue requested for review.

ORTHOMERICA® star band®
p (877) 737-8440 • f (877) 737-8445
custserv@orthomerica.com

Customer Name _____ Customer Number _____ Order Number _____ Fit/Delivery Appointment Date _____

Primary Complaint or Issue

When was the issue/complaint first observed?

○ Prior to fitting orthosis to patient ○ Initial fitting of the orthosis to the patient ○ Follow up appointment
○ Email or phone call from caregiver ○ Other

Did you make adjustments to attempt to resolve the issue?

○ Yes ○ No *If yes, what was done?*

Was the spacer being used in the side opening? ○ Yes ○ No ○ N/A

How long was the patient able to wear the orthosis before the decision was made to discontinue use/remake the orthosis?

Choose most accurate ○ Did not deliver to patient ○ Hours ○ Days ○ Weeks ○ Months

Measurements *Required for fitting issues at delivery or follow up appointments. Measurements may be obtained from calipers or scan.*

Taken at scan or cast to order

Mx obtained by ○ Scan ○ Calipers

Circumference _____

Cranial Width _____

Cranial Length _____

Taken when issue was noticed

Mx obtained by ○ Scan ○ Calipers

Circumference _____

Cranial Width _____

Cranial Length _____

Measurements at ear openings and cheek extensions prior to modification
Required for trim line complaint

Width of ear opening

Left _____

Right _____

Width of cheek extension

Left _____

Right _____

Pictures

Skin irritation — requires photos of patient's skin showing the irritation

Tipping/rotation or trim line — requires photos of the band on the patient- front, left and right profile, top down

Orthosis quality received from OPI — requires photos of complaint prior to attempted modification.

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Perceived Patient Compliance

Is the full time wear schedule being followed? ○ Yes ○ No ○ N/A

Additional Information:

Is the recommended cleaning protocol and schedule being followed? ○ Yes ○ No ○ N/A

Additional Information:

What is being used to clean the orthosis? *Required for skin irritation*

Is lotion/ointment/topical medication being used on the patient's skin? *Required for skin irritation* ○ Yes ○ No ○ N/A

If yes, what?

Additional information or feedback from the clinician or caregiver.

For internal use only

CQR number _____

RA number _____
(if applicable)

