CRANIAL CUSTOMER FEEDBACK FORM

CQR/RA—international

This completed form and accompanying photos take the place of returning the orthosis.

ORTHOMERICA® starband®
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 (REQUIRED)

Skin Irritation — Requires photos of patient's skin showing the irritation

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

Orthosis quality received from OPI — Requires pictures 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)

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