ORTHOTICS & PROSTHETICS
OF PINEHURST

Danny Ellis, CP
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LOWER EXTREMITY PROSTHETIC PRESCRIPTION

Patients Name: _____ Date of Birth: _____
__Male __ Female Height: _____ Weight: _____

Activity Level: K0 K1 K2 K3 K4 **Limb Loss:** __Right __Left __Bilateral **Date of Onset:** _____

Reason for amputation: _____

Level of Amputation: __Below Knee __Above Knee __Syme **Diagnosis Code:** _____

Design: __Preparatory __Definitive __Replacement Socket Only

Related to:
__New Amputation: Surgery Date_____ __Worn out Components: Date Received_____
__Changes in weight: Initial weight_____ Current weight_____
__Change in activity Level: __Increase __Decrease
__Residual limb atrophy __Anatomical change
Additional Information:
_____
_____

Prosthetic Supplies: __Socks __Shrinkers __Sheaths

Repairs:_____
_____

The above prescribed devices are a medical necessity to increase the patient's safety and functional status. The patient's residual limb is well healed and ready for a prosthetic fitting. The primary objectives in fitting the patient with a prosthesis is to enhance their independence in performing daily activities, and to improve their quality of life. The goal is keep the patient ambulating and functioning on their own. For lower limb absence, the primary issues are safety, stability, and the ability to ambulate in a manner consistent with their overall health.

Duration of Necessity: _____ **Prognosis:** _____

NOTE: A PHYSICIAN'S SIGNATURE IS MANDATORY

Physicians Signature: Date: