CRANIAL REMOLDELING ORTHOSIS FORM

Today's Date: _____ Patient: _____

Facility: _____ Age: _____ Sex: _____ Ht: _____ Wt: _____

Street: _____ Diagnosis: ☐ Plagiocephaly ☐ Brachycephaly

_____ Other: _____

City: _____ State: _____ Zip:_____ Date Cast Taken: _____

Orthotist: _____ Delivery Date: _____

Phone Number: _____ PO Number: _____

Cast Information

Cast Impression: ☐ Unmodified Negative Cast ☐ Modified Negative Cast

Description of Cranial Form (please indicate all applicable conditions):

Occipital Area: ☐ Flattening Left ☐ Bilateral ☐ Right

Facial Deformity Ear Anterior Shift: ☐ Right ☐ Left

Frontal Bossing: ☐ Right ☐ Left

Elevated Cranial Height: ☐ Right ☐ Left ☐ Posterior

Measurements

Temporal Width: _____ Biparietal Width: _____ Crown Circ.: _____

Transcranial (Diagonal) AP Measurements

Left Anterior to Right Posterior: _____ Right Anterior to Left Posterior: _____

Orthosis Information

Side Opening: ☐ Left ☐ Right

Attach Chafe: ☐ Anterior to slot ☐ Posterior to slot ☐ Send – do not attach

Transfer Paper Design: _____ Positive Image Transfer: _____

Select Material

Copolymer: _____

HD Polyethylene: _____

Liner Thickness & Density

___ _____ Soft _____

___ _____ Medium _____

Trim lines should be clearly indicated on the mold.

Special Instructions: _____