Ambulatory Footwear Inc.

6 Osler Court, Dundas, ON, Canada L9H 4L3
Phone 905-628-5778 Fax 905-628-3789
Makers of quality custom-made Footwear, Orthoses, and Bracework

Consent Form

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with appropriate product and service pertaining to my foot care, Ambulatory Footwear will collect some personal information about me.

I agree to Ambulatory Footwear collecting, using and disclosing personal information about me as required to my family doctor or other healthcare providers involved in my care.

I agree to Ambulatory Footwear submitting information about me and my condition to relevant third parties such as my insurance provider or community / social services in order to make any claims regarding product and service provided.

CONSENT FOR TREATMENT

I hereby consent to be treated by a member of the clinical staff at Ambulatory Footwear, who is also a certified member of the College of Pedorthics Canada.

I understand that I may or may not respond to therapy prescribed in my course of treatment. I understand that I am responsible for following any course of treatment prescribed and that I am free to ask any questions related to my condition and treatment.

Signature: _____ Date: _____

Printed Name: _____

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reception@afw.ca
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Client #_____

ASSESSMENT

DEMOGRAPHIC INFORMATION

Patient Name: _____	**Date of Assessment:** _____
Address: _____	**Date of Birth:** _____ **Age:** _____
City: _____ **Postal Code:** _____	**Gender:** _____ **Height:** _____ **Weight:** _____
Phone: _____	**Occupation:** _____
Email: _____	**Activities:** _____

Primary Diagnosis: _____ **Referring Physician:** _____

Funding: VAC WSIB NIHB ODSP INS Other:_____

MEDICAL HISTORY

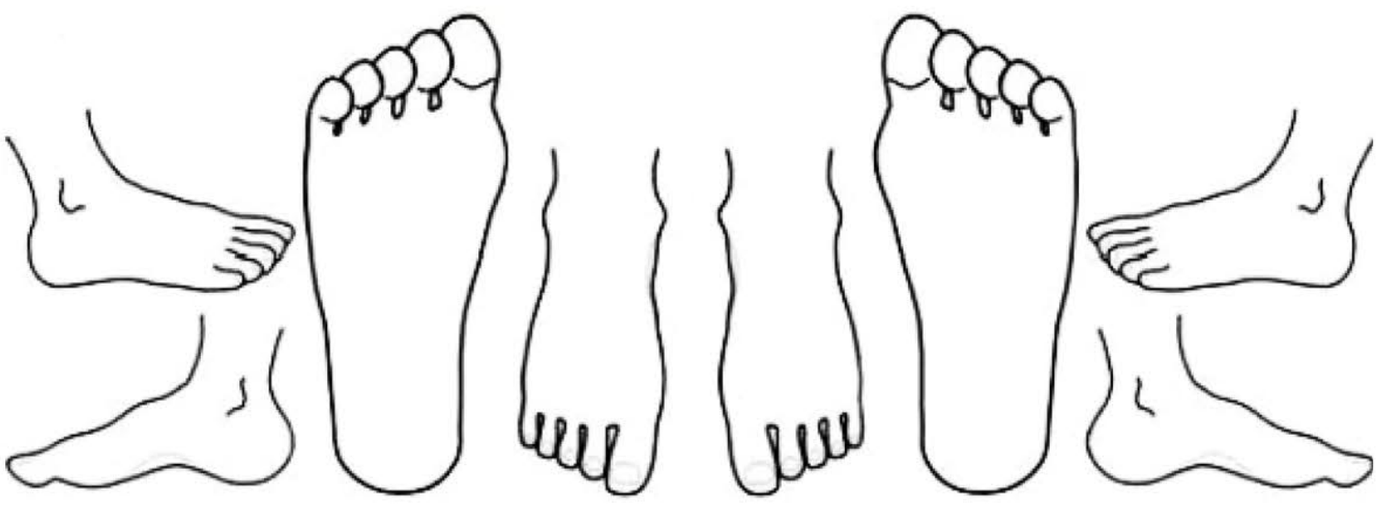
Diabetic: _____ **PVD:** _____ **Arthritis:** _____ **Neuropathy:** _____ **Leg Length Discrepancy**: L / R short by _____ mm

Previous Injuries/surgeries: _____

Other: _____

Chief Complaint:	
When:	Onset: Time of Day:
Pain Condition: _____ / 10	sharp / dull / neuropathic / swelling / stiff / throbbing / unstable / other: _____
Aggravating / Relieving Factors:	
Previous Treatments:	
Footwear Styles:	
Footwear Size:	
Abnormal Wear Patterns:	

SKIN CONDITION (mark location)



RIGHT **LEFT**

Notes:

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BIOMECHANICAL & GAIT ASSESSMENT

Patient Name:	**Date of Assessment:**

Patient History:

☐Pes Planus	☐Bunion	☐Neuroma	☐Foot Pain
☐Pes Cavus	☐Heel Spur	☐ITB Syndrome	☐Ankle Pain
☐Pes Equinus	☐Hallux Valgus	☐Patello-Femoral Pain Syndrome	☐Knee Pain
☐Plantar Fasciitis	☐Claw Toe(s)	☐Achilles Tendonitis	☐Back Pain
☐Leg Length Discrepancy	☐Hammer Toe(s)	☐Tibialis Posterior Tendonitis	☐Hip Pain
☐Hallux Limitus / Rigidus	☐Metatarsalgia	☐Diabetic	☐Other:_____

BIOMECHANICAL EVALUATION

		Right	Left
NON-WEIGHT BEARING	**Calcaneal Position**	Varus / Neutral / Valgus	Varus / Neutral / Valgus
	Forefoot Alignment	Varus / Neutral / Valgus	Varus / Neutral / Valgus
	First Ray Position	Dorsiflexed / Neutral / Plantarflexed	Dorsiflexed / Neutral / Plantarflexed
	Hallux Valgus	Normal Angle / Increased / Severe	Normal Angle / Increased / Severe
	Digital Deformities		
	Leg Length Discrepancy	ASIS Measurement: _____mm	ASIS Measurement: _____mm
		Structural	Functional
RANGE OF MOTION	**Ankle Joint ROM**	Adequate / Limited	Adequate / Limited
	Subtalar Joint ROM	Restricted / WNL / Hypermobile	Restricted / WNL / Hypermobile
	Midtarsal Joint ROM	Restricted / WNL / Hypermobile	Restricted / WNL / Hypermobile
	First Ray ROM	Restricted / WNL / Hypermobile	Restricted / WNL / Hypermobile
	Hallux ROM	Normal / Limited / Rigid / FHL	Normal / Limited / Rigid / FHL
WEIGHT BEARING	**(NWB) Arch Height (WB)**	1 2 3 4 5 Low Medium High 1 2 3 4 5	1 2 3 4 5 Low Medium High 1 2 3 4 5
	Calcaneal Position	Varus / Neutral / Valgus	Varus / Neutral / Valgus
	Knee Alignment	Straight / Varum / Valgum / Recurvatum / Internal Rotation / External Rotation	Straight / Varum / Valgum / Recurvatum / Internal Rotation / External Rotation

GAIT ANALYSIS

	Left	Right
Heel Strike	Pronated Neutral Supinated	Pronated Neutral Supinated
Midstance	Pronated Neutral Supinated	Pronated Neutral Supinated
Toe-off	Pronated Neutral Supinated	Pronated Neutral Supinated
Angle of Gait	Straight In-Toe	Out-Toe Severe In-Toe

Notes:

Certified Pedorthist:

Date Dispensed:

Please be advised Ambulatory Footwear is a manufacturer of custom orthopedic footwear and foot orthoses. All work is done on-site, as such there is no lab invoice.

Casting Technique: Non-weight bearing 3D volumetric cast in subtalar neutral (plaster bandage, STS sock, or foam box).

Fabrication Technique: Orthoses are constructed using 100% raw materials and created from a 3D cast of the client's feet. Modifications to the castings are made, if necessary, according to each client's needs. The devices are then vacuum-formed from a thermoformable material directly over the positive molds. All custom made appliances are fabricated on site, unless otherwise stated.

Raw Materials: Shell and posting material include Subortholen, Polypropylene, Carbon Fibre, Cork, Plastazote and various densities of Ethyl Vinyl Acetate (EVA). Top cover materials include, but are not limited to Microcell Puff, P-cell, Leather, PPT, and Vinyl.

Prognosis: The gait anomalies, anatomical situations and existing foot related problems can be managed by the custom foot orthotic devices while wearing them, but they will not perform a structural reformation of the foot while not wearing the devices. The custom foot orthotic devices are a prescribed medical necessity and must be worn on a daily basis for an indefinite period of time. Wearing custom foot orthotic devices may alleviate symptoms experienced in the foot, lower leg, knee, hip and back. The custom foot orthotic devices, feet and gait should be regularly monitored to watch for a change in the prescription or for the breakdown of the device.