

Patient Information

 Last Name First Name

 Address Sex M F

 City Zip Code DOB

(_____) _____ (_____) _____
 Phone Emergency Phone

 Insurance Company Name / Insurance ID

Prescriber Information

 Doctor's Last Name Doctor's First Name

 Facility Name

 Facility Address

(_____) _____ (_____) _____
 Phone Fax

 Doctor's License # Doctor's NPI #



Night Splint / Foot Drop Splint L1930

The HealWell Night splint is designed to comfortably position the foot in a controlled amount of dorsiflexion to provide a gentle stretch to the plantar fascia and Achilles Tendon. This gentle stretch helps reduce the muscle contracture, inflammation and associated pain. It has also been clinically proven to reduce symptoms of plantar fasciitis.

- INDICATIONS:**
- Foot drop
 - Weak muscles
 - Peripheral neuropathic disorders
 - Post surgical Achilles tendon repair

Plantarflexion Contracture Greater than 10 degrees

- Uncontrollable, Severe Plantarflexion
- Spasticity Weight Bearing Activities

Item Description: L1930 Ankle foot orthosis, plastic or other material, prefabricated, includes fitting and adjustment

Features of the Night Splint:

- Comfortably positions the foot in a controlled amount of dorsiflexion (0°-10°)
- Adjustable bilateral dorsiflexion straps
- Easy push lock buckles
- Three strategically placed comfortable padded straps
- Removable foam wedge provides additional toe extension
- Removable C3 liner with Orthowick to help wick moisture into the Microban foam inner layer
- Strong Kydex plastic helps prevent torquing at critical areas
- Liner is treated with Microban Antimicrobial Protection, an agent that is part of the liner's molecular structure and helps to provide continuous control over the growth of certain odor and stain causing bacteria, yeast and fungi
- Lightweight, low-profile
- Made of spring-action plastic with ventilated calf area to allow for comfort and breathability
- Open, cut heel design allows for the foot to be comfortably and properly positioned

ICD-9 Code: 728.71 Plantar Fascial Fibromatosis

PLEASE SPECIFY ANKLE FOR TREATMENT: RIGHT LEFT BILATERAL

Length of need is 99 months (unless specified) Other: Month(s)

<input type="checkbox"/> SMALL	<input type="checkbox"/> MEN'S 6 or smaller	<input type="checkbox"/> WOMEN'S 5 or smaller	<input type="checkbox"/> MEDIUM	<input type="checkbox"/> MEN'S 6 - 8	<input type="checkbox"/> WOMEN'S 7 1/2 - 9 1/2	<input type="checkbox"/> LARGE	<input type="checkbox"/> MEN'S 8 1/2 - 10 1/2	<input type="checkbox"/> WOMEN'S 10-12	<input type="checkbox"/> XLARGE	<input type="checkbox"/> MEN'S 10-13	<input type="checkbox"/> WOMEN'S 12+	<input type="checkbox"/> XXLARGE	<input type="checkbox"/> MEN'S 13+	<input type="checkbox"/> WOMEN'S —
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According to US shoe size