

FRIENDSHIP VENTURES
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Annandale, MN 55302
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www.friendshipventures.org

Session _____ Cabin _____

Cabin copy _____
Nurse copy _____

ORTHOPEDIC APPLIANCES QUESTIONNAIRE (SPLINTS, BRACES, PROSTHESES)

This form **MUST BE RECEIVED IN THE FRIENDHIP VENTURES OFFICE 2 WEEKS PROR** to participation in any program.

Please plan to spend time with the nurse at check-in to review this form.

PLAN TO SPEND SUFFICIENT TIME WITH OUR COUNSELORS TO DEMONSTRATE USE OF THE APPLIANCE.

PARTICIPANT NAME: _____ **DATES ATTENDING:** _____

Please indicate **type of appliance** used: _____

To what **body part** is appliance applied? _____

***** Please clearly mark LEFT and RIGHT on the appliance, prior to arrival to this program.**

What is **worn under** the appliance? _____

What special skin care is required? _____

Please indicate the **schedule for use of the appliance**: time on: _____ time off: _____

Appliance may be **taken off** for the following reasons: _____

Is appliance to be: (check any that apply) off during nap /rest hour? _____ off for bathing/swimming? _____

If redness or skin break-down occur under the appliance, can it be left off for a period of time? _____

If so, **how long?** _____

Please use the space below for any additional information:

NAME OF PERSON COMPLETING FORM

Relationship to applicant

PHONE

DATE

THANK YOU!

Revised: 2-08