Taos Patient Qualification Form

Patient Name_________________________

Age:__________ Gender: Male___ Female ___

Parent/Guardian Name:____

Parent/Guardian phone ______________________________ (Sky Medical will contact the parents with a brief phone call to answer any questions they may have about the Taos system.)

Referring Physician:____

Obtained doctors prescription for Taos: Yes ______ No______

Therapist Name____________________ Phone number_________________

Orthotist Name:____________________ Phone Number________________

Insurance Provider ___________________ Policy Holder_____________________

Insurance Policy Number_____________

Taos Requirements:

- Patient must weigh less than 120 pounds
- Patient must be shorter than 60"
- Patient's Pelvic width must be at least 5.75"
- Patient's femur must be at least 4"
- Patient must have a knee center to floor length of at least 6.5 "

Please Answer the Following Questions: (*If any questions are answered no, please contact Sky Medical at 888-769-6084 as we may need to make special accommodations for this child*)

- Can the child bear any weight through his/her legs? ☐ Yes ☐ No
- Can the child push at all with his/her legs? ☐ Yes ☐ No
- Can the child extend his/her knee within 20 degrees of full extension? ☐ Yes ☐ No
- Can he/she extend/achieve ankle position within 20 degrees of neutral? ☐ Yes ☐ No
- The child is free of severe scoliosis? ☐ Yes ☐ No
- Is the child free from other health issues that could be exacerbated from use of the Taos, (Frequent seizures, Respiratory problems, cardiovascular problems)? ☐ Yes ☐ No
- Has the family been informed on the realistic expectations they should have for their child in the Taos? ☐ Yes ☐ No
- Is the family committed to incorporating the Taos into their child's routine? ☐ Yes ☐ No
- Does the family have access to an area to use the Taos? ☐ Yes ☐ No

Provide notes describing any leg length discrepancies, rotational issues, contractures or other patient specific issues that might be important for the orthotist:_____________________________

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Please fax this form to Sky Medical 954-747-3189