



LOWER EXTREMITY OSTEOARTHRITIS, INJURY, AND PRE / POST-SURGERY SOLUTIONS

PATIENT NAME: _____ DATE: _____

HEALTH CARE PROFESSIONAL: _____ MSP#: _____

SIGNATURE: _____ CONTACT #: _____

DIAGNOSIS + SPECIAL INSTRUCTIONS

Required

TREATMENT REQUESTED (OR CHECK SERVICE BELOW)

OA/INJURY/POST-SURGICAL BRACING AND OTHER SOLUTIONS

Some items may require appointment.

KNEE	FOOT / ANKLE	POST-OP EQUIPMENT	OTHER SPECIFIC REQUEST
<input type="checkbox"/> OA Unicompartmental / Meniscus Unloader <input type="checkbox"/> MEDIAL <input type="checkbox"/> LATERAL <input type="checkbox"/> Tricompartmental Unload (Springloaded Levitation) <input type="checkbox"/> OA Soft Support <input type="checkbox"/> Ligament Stability <input type="checkbox"/> ACL <input type="checkbox"/> PCL <input type="checkbox"/> MCL <input type="checkbox"/> LCL <input type="checkbox"/> PCL Post-Op / Acute Injury (Ossur Rebound PCL) <input type="checkbox"/> General Compression / Stability <input type="checkbox"/> Patellar Stabilizer <input type="checkbox"/> Patellar Strap <input type="checkbox"/> Post-Op Knee ROM Bracing	<input type="checkbox"/> Walking Boot <input type="checkbox"/> STANDARD <input type="checkbox"/> SHORT <input type="checkbox"/> Achilles Wedge Kit <input type="checkbox"/> Ankle Ligament Brace <input type="checkbox"/> Richie Brace <input type="checkbox"/> Custom Foot Orthotics (Health Benefits may require referral to community partner) <input type="checkbox"/> Prefabricated Arch Support <input type="checkbox"/> Night Splint - Foot/Ankle <input type="checkbox"/> Night Splint - Bunion <input type="checkbox"/> Drop Foot Brace <input type="checkbox"/> Other _____ HIP <input type="checkbox"/> Ossur Hip Unloader <input type="checkbox"/> SI Belt	<input type="checkbox"/> Knee ROM Post-Op Bracing <input type="checkbox"/> Cryotherapy Unit and Pad <input type="checkbox"/> Walking Boot Achilles Wedge Kit <input type="checkbox"/> STANDARD <input type="checkbox"/> SHORT <input type="checkbox"/> Muscle Stimulator (e.g. Enovis Compex) <input type="checkbox"/> Other _____ CRYOTHERAPY <input type="checkbox"/> Ossur Cold Rush (or similar) <input type="checkbox"/> Other _____ COMPRESSION <input type="checkbox"/> Everyday (20-30MMHg) <input type="checkbox"/> Medical Grade (20-30MMHg) <input type="checkbox"/> CALF <input type="checkbox"/> THIGH <input type="checkbox"/> WAIST <input type="checkbox"/> Other _____	

ADD PHYSIOTHERAPY SERVICES

As Determined by PT
 OA Treatment (Individualized Exercise, Education, Self-Management)
 Specific Rehab Protocol (Specify) _____
 Surgical Preparation (Exercise / Education)

Post-Surgical Rehab (Specify) _____
 Extracorporeal Shockwave Therapy
 Manual Therapy
 Other (Specify) _____



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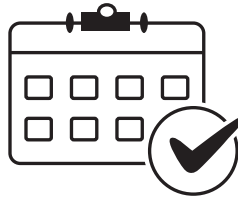
Lower Extremity Osteoarthritis/Injury/Post-Op Solutions services managed and provided by Jeremy McAllister, Registered Physiotherapist, MHA

Jeremy brings over 30 years of experience in injury/
osteoarthritis/post-surgical physiotherapy, custom
bracing/orthotics, and health systems management



Virtual Consults

Call or email to request
a virtual assessment of
your needs



Appointments are required for:

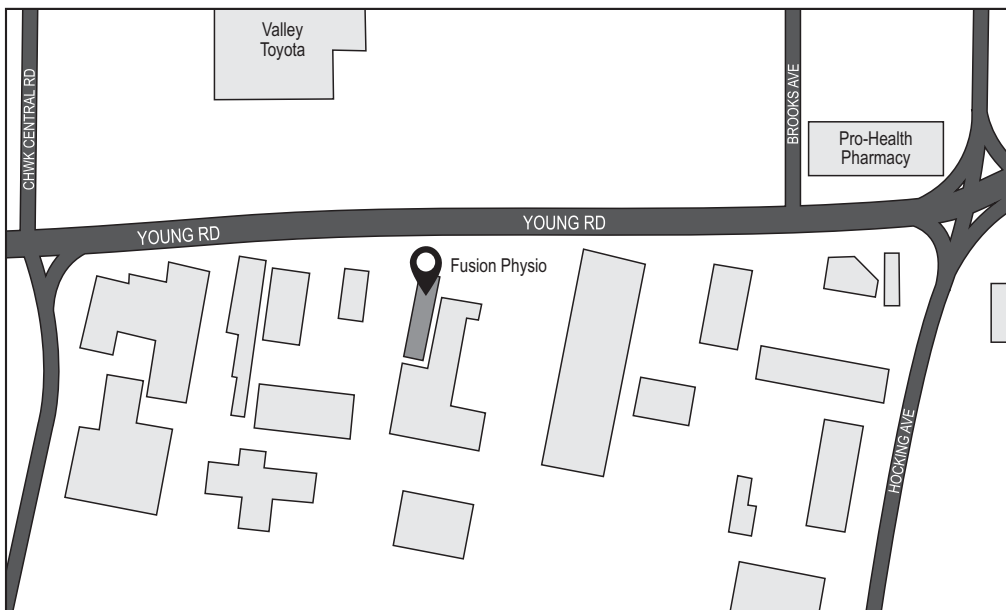
Unloader Knee Bracing
Ligament Knee Bracing
Custom Foot Orthotics
Ankle Foot Orthosis
Medical Grade Compression



Questions about
our services, insurance
coverage or need a quote?

EMAIL US AT:
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OUR LOCATION



OUR PARTNERS

