

Op OrthoPro of Reno

Custom Orthotics & Prosthetics

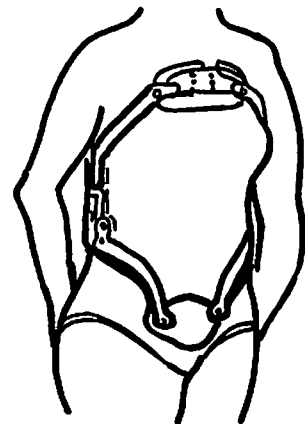
Date:

Patient Name:

Spinal Orthoses

L0300-L0960, L0300-L0440- TLSO, L0500-L0960-LSO

You have been fit with a Spinal Orthosis. Unless otherwise instructed, please use a gradual break in schedule to allow your body to get used to the device. Start with an hour today. Increase an hour per day as tolerated. Following use, remove your orthosis and inspect your skin. There may be some skin redness from pressure areas. Redness should not persist for more than 15 minutes after removal. Redness that does not disappear can be a sign of excess pressure. Discontinue use, also, if any sign of numbness, tingling, color change, excessive itching, swelling or pain develops. Please contact our office for adjustments and do not reapply orthosis. Failure to do so could lead to blisters or open sores.



Your orthosis may look different.

The orthosis is designed to support your back and limit the motion of your spine. Usually, this device is worn anytime you will be out of bed. However, some conditions require 24 hour per day usage. You may need to check with your doctor. [T]LSOs or back braces should always be worn over a snug shirt, preferable cotton. Unless your doctor instructs you differently, your orthosis should be put on before you get up out of bed. It is important that the waist grooves—indentations in the sides of the orthosis—line up with your waist. Pull all straps snug until the orthosis cannot be shifted on your body.

Your orthosis can be cleaned with a wash cloth and mild soapy water. Saddle soap can be used on leather portions. Make certain all soap residue is removed and the orthosis is completely dry before re-applying.

Make sure you are comfortable with how to properly put on and take off your orthosis. Never attempt to modify your orthosis yourself.

Please inspect your orthosis daily for any signs of wear including cracking, loose parts, or decreased effectiveness of the device and call our office as needed. A yearly check up is recommended.

Patient Signature _____ Date _____