Instructions & Care Plan for the Comfy™ Adult & Pediatric Elbow Orthoses (E-101,2 & PE-101,2)

1. Write patients last name on both covers using permanent marker or indelible ink. **2.** Open Velcro straps.

3. After passive range of motion of the elbow, to allow maximum elbow extension, place Orthosis along the inside flexor surface of the elbow.

4. The **Comfy™** ELBOW splint can be adjusted to different degrees of extension or flexion of the elbow as desired and the lateral "wings" or cuffs can be adjusted to the patient's arm and forearm. Merely press the Orthosis against a firm edge (e.g. table, countertop or chair edge) while firmly holding and leaning on both ends. Do not remove insert from fabric cover, as all positioning can be done while insert is in the cover. The ***Comfy™*** Orthosis is easily adjusted and re-adjusted to any desired angle and maintains its shape. Several adjustments can be performed rapidly to obtain the desired optimal angulation.

5. Once the desired angulation for the elbow is achieved, wrap the straps around the arm and forearm and secure with Velcro. Note the middle, split strap has an opening for the elbow. It is suggested that the therapist maintain a two finger space under the straps to prevent excessive pressure areas on the patient's skin.

6. Check ***Comfy™*** splint every 15 minutes initially then increase intervals to every two hours, for pressure areas, edema, or skin irritation. *If signs of redness, increased swelling or pain appear - discontinue use and notify physician.*

To Change Terry Cloth Cover: Merely unzip cover and remove. Launder in warm sudsy water. Air dry or tumble dry at medium setting. Do no wash or dry at high temperatures.
The Comfy™ ELBOW Orthosis requires a physician prescription and should be applied and supervised by a trained healthcare professional. If any of the metal frame becomes exposed, cease using the device.

If signs of redness, swelling or pain appear - discontinue use, and notify physician.

CARE PLAN

INTRODUCTION: The **Comfy™** Elbow Orthosis is a patient specific product that can be easily fitted and labeled for single patient use upon order of a physician. It should be used only in connection with a care plan and custom fitting instructions by a trained health care professional.
INDICATIONS: This Orthosis is to be used with patients who present with elbow flexion pattern, arthritic changes and any deformity related to neuromuscular impairment.
RESULTS: The **Comfy™** Elbow Orthosis will help increase/maintain elbow extension. It also prevents further deformity, maximizes ROM, and makes maintenance of good hygiene of the involved extremity easier. The terry cloth cover helps absorb moisture and allows for air circulation, thereby helping prevent skin maceration.
CONTRA-INDICATIONS: The **Comfy™** Orthosis should not be used if the patient has any circulatory problems, pressure areas or skin irritations.
FITTING INSTRUCTIONS: The **Comfy™** Elbow Orthosis should be applied and fitted *only by a trained professional*. Fit and shape Orthosis according to patient's requirements and as indicated in instructions. Check Orthosis fit and place two fingers under strap to ensure strap is not too tight.

WEARING TOLERANCE: Check Orthosis at least every two hours until removed, to see if there are any problems such as skin abrasions, redness, blisters, or increased edema (if straps are too tight). With patients who have sensory deficits, the Orthosis should be checked more frequently.

MAINTENANCE OF ORTHOSIS: The Cover of the **Comfy™** Orthosis is designed to be removed for laundering. The fabric cover can be washed by hand or by machine in lukewarm water. Do not use bleach or hot water. Air or tumble dry on cool or warm setting. The bend-able white insert can be cleaned by wiping both sides with a solution of warm water and detergent or with disinfectant. If any of the metal frame becomes exposed, cease using the device.

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Assessment Form
Comfy™ Upper Extremity Orthoses

Patient Name: ________________________ **HICN #:**__________ **Room #**______

Facility: _______________________________________ **Date:** ______________

Address: ____

Primary Diagnosis: ____________________ **Secondary Dx:**___________________

Prognosis: Good _______ Fair _________ Poor

Mobility: Ambulatory _______ Wheelchair confined________ Bed confined______

Communication: Makes Needs Known ______ Unable to make needs known

U.E. Sensation: Intact ____ Moderately Impaired ______ Severely Impaired

U. E. Active R.O.M.: WNL _____ Mildly Restricted ______ Severely Restricted

U. E. Passive R.O.M.: WNL ____ Mildly Restricted _______ Severely Restricted

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Diagnosis	Rt	Lt	Severity/Comments
Wrist drop			
Wrist Contracture			
MP Contracture			
Finger jnt. Contracture			
Elbow Contracture			
Decr. muscle strength			
Decr. ADL function			
Joint Pain			
Ulnar/Radial Deviation			
Pressure Sores			
Hygiene deficits			

	Treatment Goals
	Prevent Fixed Contractures
	Support Flaccid Hand, Wrist, or Elbow
	Manage Arthritic Joint Deformities
	Decrease pain
	Control Ulnar or Radial Deviation
	Improve Muscle Strength
	Improve A.D.L. Function
	Increase Range Of Motion
	Decrease Pressure Areas
	Increase Hygiene
	Increase U.E. function

Treatment Plan:

_____Wrist-Hand-Finger Orthosis (H101)
_____ Finger Extender Hand Orthosis (F101)
_____ Dorsal hand Orthosis (DORSH101)
_____ Slim Hand (CHSlim)
_____ Deviation Standard Hand (DH101)
_____ Elbow Orthosis (E101)
_____ Spring Loaded Elbow (SGE101)

_____ Finger Separator (FS1)
_____ Long Pan Hand Orthosis (LPH101)
_____ Opposition Thumb Hand (OPH101)
_____ Slim Wrist (CWSlim)
_____ Deviation Finger Extender (DF101)
_____ Goniometer Elbow Orth. (GE101)
_____ Adjust Hinge Eblow Orthosis (Adj-E101)

_____ Hand Thumb Orthosis (HT101)
_____ Long Opponens Hand Orthosis (LOPH101)
_____ Comfy Grip hand Orthosis (OPH101)
_____ Spring Loaded hand Orthosis (SH101)
_____ Elbow Hand Combination (EH101)
_____ Push Button Goni. Elbow (PBGE101)
_____ Dynamic Torque Elbow Orth. (Torq1-E)

Observe from 15 min to 30 min intervals; Then Graduate to 1-2 hr Intervals; Remove and check for pressure areas every shift.
I certify active treatment of this patient. This equipment is part of my recommended treatment and is "reasonable and medically necessary". The above information is true and accurate, to the best of my knowledge.

Physician's Signature ________________________________ Date: ______________
Phone: _________________ UPIN#:______________
Address:____

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