State of Illinois
Department of Healthcare and Family Services

Questionnaire and Order For Cranial Remolding Orthosis or Cranial Cervical Orthosis Congenital Torticollis Type

Patient Name: _____ DOB: _____ SEX: _____

RIN: _____ Order for: _____

1. Indicate the primary diagnosis:
   - ☐ a. Deformational plagiocephaly
   - ☐ b. Symmetrical deformational brachycephaly
   - ☐ c. Asymmetrical deformational brachycephaly
   - ☐ d. Other _____

2. Indicate any secondary diagnoses that are contributing factors to the skull deformation:
   - ☐ a. Prolonged hospitalization
   - ☐ b. Restricted intrauterine environment
   - ☐ c. Cervical vertebral anomalies
   - ☐ d. Torticollis
   - ☐ e. Limited cervical range of motion without torticollis
   - ☐ f. Developmental delays
   - ☐ g. Birth trauma (specify:) _____
   - ☐ h. Supine sleep position (“Back to Sleep”)
   - ☐ i. Other (specify) _____
   - ☐ j. Prematurity (specify estimated gestational age at birth) _____weeks

3. Indicate the duration of conservative repositioning therapy in months: _____

4. If physical therapy has been consulted, indicate the duration of this therapy: _____

5. Does the patient have craniosynostosis?
   - a. Yes ☐
   - b. No, as determined by which of the following:
     - Clinical examination ☐
     - Imaging ☐ Plain radiographs ☐ CAT scan ☐

6. Submit actual anthropometric skull measurements including head circumference and diagrams to allow calculation of cephalic index, cranial vault asymmetry, orbitotragial depth asymmetry, and cranial base asymmetry.

7. Submit orthotic consultation, consultative reports from physicians, operative reports for craniosynostosis and radiographic reports if available, and scans/diagrams/photographs demonstrating the deformity, if the latter are available

_____ _____

Practitioner's Signature with degree: Date

Office Phone #: _____ Fax: _____ NPI: _____