

FITTING INSTRUCTIONS:

Jaw Dynasplint® System



To wear seated you will attach both counterbalance arms.

Pinch the mouthpiece closed. Open mouth and insert the plastic mouthpiece as far as possible comfortably.

To wear laying on back- Do not use the counterbalance arms and follow the above instructions to don the splint.

CLINICIAN'S PRESCRIBED TREATMENT SCHEDULE

These are guidelines only. Remove the Dynasplint® System if you experience pain at any time and contact your Dynasplint Systems Sales Consultant.

Please note: Prolonged Duration stretching is more beneficial. This means that the longer each day you can wear the Dynasplint® System without exceeding 8 hours per day, the better the recovery of your ROM. However, even as little as one hour total throughout the day can be beneficial. The total time each day you wear the Dynasplint® System is dependent on many factors including: How much time you have to give to this treatment each day (evening and night); the doctor and therapist's instructions, what your Dynasplint Sales Consultant advises and the overall condition of your body part needing this treatment. Please speak to your Dynasplint Sales Consultant for the best wearing schedule to fit your needs.

Tension to be initially set at _____ increments.

Patient will wear the Dynasplint® System for _____ minutes the first day.

- If no more than one hour post-wear discomfort occurs, the patient may increase wear time according to the recommended daily wearing schedule. Time spent wearing the splint is the most important component of regaining range of motion.
- Decrease tension If unable to wear for extended period of time.
- Remember to wear the Dynasplint® System while inactive, preferably resting.

The basic protocol outline is to provide maximum benefit from the Dynasplint® System. *Increasing tension faster does not ensure a proper stretch will be applied.*

Your follow-up visit is: _____. Please bring the Dynasplint® System and the completed evaluation sheet to your visit.

I ACKNOWLEDGE RECEIPT OF THESE PATIENT INSTRUCTIONS, WHICH I HAVE READ FULLY AND UNDERSTAND.

SIGNATURE: _____ PRINT NAME: _____

DATE: _____



PATIENT DYNASPLINT® PROGRAM

PATIENT NAME: _____

DATE OF BIRTH: _____

Ordering Physician _____

PT, OT, or Clinic Name _____

INSTRUCTIONS ON HOW TO USE THIS FORM:

1. Please track your **daily** progress in the boxes below with the the frequency and duration of how long you are wearing the Dynasplint®; and any comments you would like to add about how you are feeling.
2. Please bring this form to your clinician follow-ups so they can note your active/passive ROM, initial and date.
3. Make sure to call or text your Dynasplint Sales Consultant on day 7, 14, 21, 28 and 60 during your recovery; or anytime you have any questions or concerns! *Note: There may be slight discomfort when taking off the Dynasplint®. Please contact your consultant if discomfort persists for more than 30 minutes.*

[To be filled out by Dynasplint Sales Consultant]:

UNIT TYPE: _____ TIME & FREQUENCY OF USE: _____

TENSION SET AT FITTING: _____ CLINICIAN MEASURED AROM: _____ PROM: _____

DAY 1	DAY 2
DAY 3	DAY 4
DAY 5	DAY 6
DAY 7 Time to turn up the tension?	FOLLOW-UP #1: CLINICIAN MEASURED AROM: _____ CLINICIAN MEASURED PROM: _____ CLINICIAN INITIALS: _____ DATE: _____
Day 7: You are off to a great start! Call or text your Dynasplint Sales Consultant to update.	

DAY 8	DAY 9
DAY 10	DAY 11
DAY 12	DAY 13
DAY 14 Time to turn up the tension?	FOLLOW-UP #2: CLINICIAN MEASURED AROM: _____ CLINICIAN MEASURED PROM: _____ CLINICIAN INITIALS: _____ DATE: _____
Day 14: Call or text your Dynasplint Sales Consultant to update.	

DAY 15	DAY 16
DAY 17	DAY 18
DAY 19	DAY 20
DAY 21 Time to turn up the tension?	FOLLOW-UP #3: CLINICIAN MEASURED AROM: _____ CLINICIAN MEASURED PROM: _____ CLINICIAN INITIALS: _____ DATE: _____
Day 21: Call or text your Dynasplint Sales Consultant to update.	

DAY 22	DAY 23
DAY 24	DAY 25
DAY 26	DAY 27
DAY 28 Time to turn up the tension?	FOLLOW-UP #4: CLINICIAN MEASURED AROM: _____ CLINICIAN MEASURED PROM: _____ CLINICIAN INITIALS: _____ DATE: _____
Day 28: Call or text your Dynasplint Sales Consultant to update.	

DAY 29-40
DAY 41-50
DAY 51-60
Call or text your Dynasplint Sales Consultant to update.

ADDITIONAL INFO:	
Total length of time using the Dynasplint®: _____	
ROM at the time of discontinued use: _____	
ROM net gain: _____	
Were you satisfied with our service and product? (Please circle one)	
YES	NO
Did you reach or exceed your recovery goals? (Please circle one)	
YES	NO
Are you currently in Physical/Occupational Therapy? (Please circle one)	
YES	NO

Don't forget to call or text your Dynasplint Sales Consultant before returning your Dynasplint®. Thank you!