TRANSTIBIAL CHECK SOCKET MEASUREMENTS

Hanger FABRICATION NETWORK

WORK ORDER #: (LAB USE ONLY)

PCC #: ______________________

BILL TO: ______________________

ADDRESS: ______________________

____

SHIP TO: ☐ SAME AS BILLING ______________________

ADDRESS: ______________________

____

SHIPPING: ☐ GROUND (FXGD) ☐ STANDARD 2 DAY (FX2D)
OVERNIGHT: ☐ PRIORITY (FX1D) ☐ 1st OVERNIGHT (FX1A)
☐ OTHER: ______________________

CLINICIAN: ______________________

CELL #: ______________________

PATIENT ID: ______________________

HEIGHT: __________ WEIGHT: __________ AGE: __________

DIAGNOSIS: ______________ **AFFECTED SIDE (Check One):**
☐ LEFT ☐ RIGHT ☐ BILATERAL

OPS INVOICE/NG ENCOUNTER: ______________________

MEASUREMENT DATE: ______________________

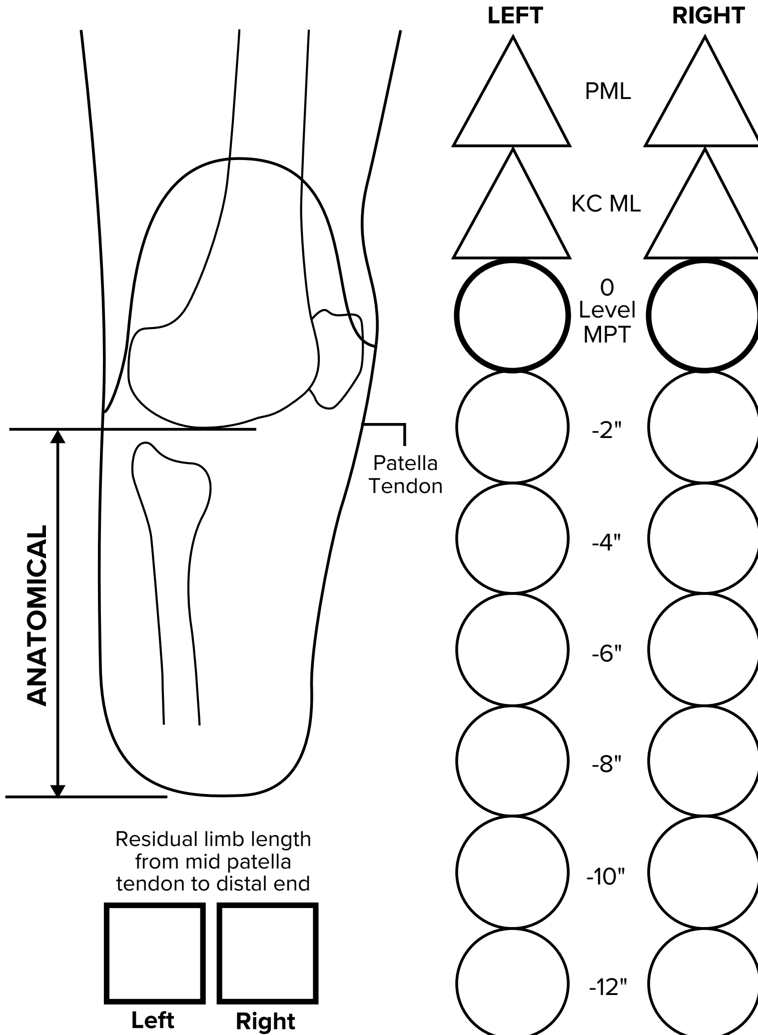
IN-OFFICE REQUEST DATE & TIME: ______________________

☐ PROJECT NEWTON (Credit applied on prior auth. denial, details on One Hanger)

HFN: ☐ PHOENIX ☐ ORLANDO ☐ KANSAS ☐ CHICAGO ☐ HOUSTON ☐ OTHER __________

Anatomical landmarks of MPT, Fibular head, and Distal Tibia must be located on the scan or cast

MEASUREMENTS TAKEN IN ☐ IN ☐ CM



ACTIVITY LEVEL ☐ K1 ☐ K2 ☐ K3 ☐ K4

LINER SCANNED/MEASURED OVER
☐ Skin ☐ Liner Type ______________

TISSUE TYPE
☐ Firm ☐ Medium ☐ Soft

REDUCTIONS
☐ **CDC Standard Reduction** (based on liner/tissue type)

Volume Reduction / Equivalent Circ. Reduction

☐ 0% ☐ 1% ☐ 2% ☐ 3% ☐ 4% ☐ 5% ☐ 6% ☐ 7% ☐ 8% ☐ 9% ☐ 10%
0.5% 1.0% 1.5% 2.0% 2.5% 3.0% 3.6% 4.1% 4.6% 5.1%

MODIFICATION TYPE
☐ TSB ☐ PTB ☐ PTBSC ☐ Vac Pin ☐ Hybrid
☐ Suction ☐ Vacuum Type__________
☐ Clinician Premodified
☐ Use Previous Model > Provide Date or CDC Order #__________

POSTERIOR SHELF
☐ None ☐ W Back ☐ Straight ☐ Diagonal

NOTES ______________________

SCAN INPUT REQUIREMENTS

SCAN TYPE ☐ Split/Inside Cast ☐ Outside Cast (Preferred) → **MEASUREMENTS** Always scan/cast and measure over the liner you are fitting with

Positive Model: ☐ Unmodfied ☐ Modified ☐ Direct Patient