

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: _____

PREFERRED CONTACT METHOD: _____

PATIENT ID: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

DIAGNOSIS: _____

AFFECTED SIDE (Check One)

LEFT RIGHT or BILATERAL: SYMMETRICAL YES NO

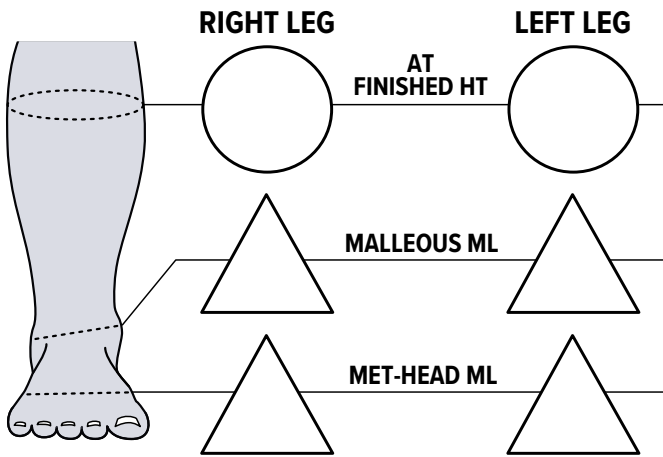
ENCOUNTER #: _____

MEASUREMENT DATE: _____

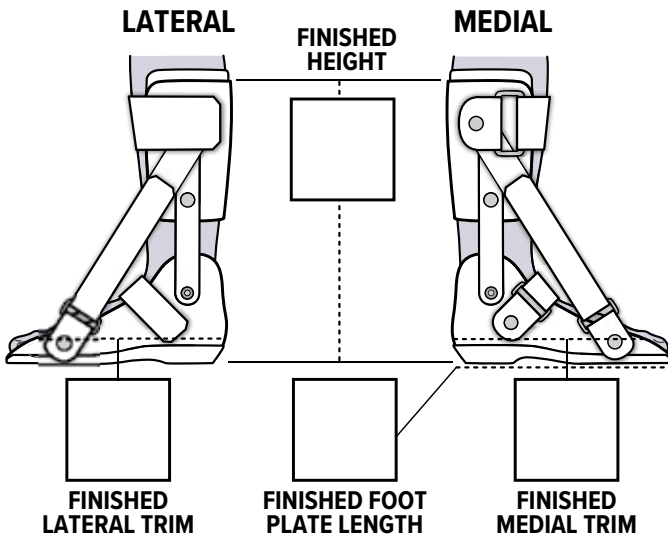
IN-OFFICE REQUEST DATE & TIME: _____

HFN: ORLANDO (scootz) HOUSTON OTHER _____

PATIENT MEASUREMENTS (REQUIRED)



DEVICE MEASUREMENTS (REQUIRED)



NOTES

MATERIAL

Plastic Type

Polypropylene Copolymer Modified Polyethylene

Thickness

3/32" 1/8" Other _____

Inner Boot Options (F3000) None

3/32 LDPE 3/32 Optiflex 1/8 Foam

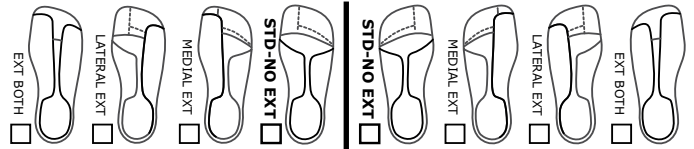
MODIFICATIONS

Footplate: None Mild Aggressive

ALIGNMENT

Right Foot			Left Foot		
Ankle Alignment			Ankle Alignment		
<input type="checkbox"/> Neutral	<input type="checkbox"/> As Casted		<input type="checkbox"/> Neutral	<input type="checkbox"/> As Casted	
<input type="checkbox"/> ___° Dorsi	<input type="checkbox"/> /Plantar		<input type="checkbox"/> ___° Dorsi	<input type="checkbox"/> /Plantar	
Heel Alignment			Heel Alignment		
<input type="checkbox"/> Neutral	<input type="checkbox"/> As Casted		<input type="checkbox"/> Neutral	<input type="checkbox"/> As Casted	
Forefoot Alignment			Forefoot Alignment		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOREFOOT TRIMLINE



Dorsal Wrap: Yes No

FINISHING

Pattern Transfer: Option 1 _____
 Option 2 _____

Additional Padding

Posterior Proximal Calf
 Navicular
 Other _____

Posting

None Full Plantar
 Heel Post Heel & Midfoot
 Other _____

Finished Unfinished (send straps unattached) None

Straps: White Other _____

Pads: White Other _____

Socks: Additional Quantity _____ Non-skid