

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: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

DIAGNOSIS: _____

AFFECTED SIDE (Check One)

LEFT RIGHT or BILATERAL: SYMMETRICAL YES NO

NG ENCOUNTER #: _____

MEASUREMENT DATE: _____

IN-OFFICE REQUEST DATE & TIME: _____

HFN: ANAHEIM ORLANDO PHOENIX

PATIENT DESIGN OPTIONS

COMPONENTS TO BE ORDERED BY: PCC HFN

LEVEL

PH WD TR ED TH SD

Other _____

SYSTEM TYPE

Passive Body Powered External Powered

SOCKET

Test Socket Definitive

COLOR

Custom Color _____

Match Lamination or Glove:

Otto Bock # _____ Fillauer # _____

Steeper # _____ Regal # _____

Other _____

ANCHORS

No Yes Qty _____

DESIGN VARIATIONS

3/4 Noodle Prepreg Carbon

Internal Flap/Ring Fiberglass Frame

Pull Tube Vivak Frame

Gel Pads Valve, Type _____

ADDITIONS

Axilla Pad

Chest Pad _____

Shoulder Saddle _____

NOTES

Large empty box for notes.