



ORDER BY DIAGNOSIS

Doctor: _____ Dx: _____

Date: _____ City: _____ State: _____

Patient Info:

Patient Name: _____ Weight Range: (1-119) (120-184) (185-249) (250+)

Shoe Size: _____ Symmetric Feet: Y / N Gender: M / F

Diagnosis Specific Orthoses:

Halux Limitus

Lateral Ankle Instability/Peroneal Tendonitis

Leg Length Discrepancy

Short Leg: R L

Length: _____

Metatarsalgia

Neuroma

Pes Cavus

Flexible Hindfoot

Rigid Hindfoot

Plantar Fasciitis

Posterior Tibialis Dysfunction

Sesamoiditis

Special Instructions:

Plantar View: Mark all trouble areas.



(Bottom View)

REORDER:
Must complete Rx form.

Fax to: 308-345-4155

Orthotic # _____
(from bottom of orthotic)

SPECIAL PROCESSING: (\$50 + Shipping)

RUSH - 3 days in lab with **Overnight** shipping

OR: 2nd Day to: Patient Dr.
Ground to: Patient Dr.