

Date: _____ PO#: _____ Account #: **ZZ5259**
 Doctor: _____
 Address: _____
 City: _____ State / Zip: _____ Phone: _____
 PATIENT NAME: _____
 Dx: _____ Med Rec #: _____

**For PROLAB
office use only**

Asymmetric Feet? Yes No Male Female Age: _____ Weight (required): _____ Shoe Size: _____ Shoe Enclosed

Select **ONLY ONE** device in Part A –OR– Complete Part B

A PATHOLOGY SPECIFIC ORTHOSES™

Achilles Tendinitis Pes Cavus with Rigid Forefoot
 Calcaneal Apophysitis Plantar Fasciitis due to Everted Rearfoot
 Hallux Limitus/HAV Plantar Fasciitis due to Forefoot Valgus
 Intoeing Gait (gait plate) Posterior Tibialis Dysfunction
 Lateral Ankle Instability/Peroneal Tendinitis Navicular sweet spot (mark on cast) R L
 Metatarsalgia Sesamoiditis
 Neuroma Sinus Tarsi Syndrome
 Pediatric Flatfoot Tarsal Tunnel Syndrome

SPECIALTY ORTHOSES

ProAerobic Med Firm
 Cobra
 Featherweight Med Firm
 Graphite Dress
 Graphite Functional
 Holethotic
 Plastazote Functional Med Firm
 UCBL

**ACCOMMODATIVE
(non-corrected)
SOFT INSOLES**
(Semi-weightbearing cast)

EVA Shell
 Med Firm
 Topcover
 3mm EVA Diabetic

B POLYPROPYLENE SHELL

Vacuum-Formed – Black
 Vacuum-Formed – Natural
 Direct-Milled (natural only; includes poly post)
 No Post

SHELL RIGIDITY

Choose Poly Thickness –OR– Choose Shell Rigidity

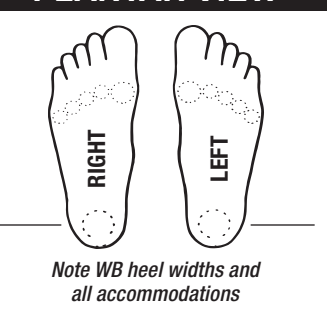
2mm (direct-milled only)
 3mm
 4mm
 5mm
 6mm

Patient Weight: _____
 Flexible
 Semirigid
 Rigid

SIZE & CASTWORK (defaults in bold)

HEEL CUP DEPTH	WIDTH	CAST FILL	MEDIAL HEEL SKIVE	INVERT	SHELL ACCOMMODATIONS
<input type="checkbox"/> Shallow (10mm)	<input type="checkbox"/> Narrow	Minimum <input type="checkbox"/> R <input type="checkbox"/> L	2mm <input type="checkbox"/> R <input type="checkbox"/> L		Medial Flange <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Standard (14mm)	<input type="checkbox"/> Standard	Standard <input type="checkbox"/> R <input type="checkbox"/> L	4mm <input type="checkbox"/> R <input type="checkbox"/> L	_____° R	PF Groove <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Deep (18mm)	<input type="checkbox"/> Wide	Maximum <input type="checkbox"/> R <input type="checkbox"/> L	6mm <input type="checkbox"/> R <input type="checkbox"/> L	_____° L	Sweet Spot (w/ Poron®) <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> _____ mm					1st Ray Cut-out <input type="checkbox"/> R <input type="checkbox"/> L

PLANTAR VIEW



REARFOOT POST	TOPCOVER OPTIONS		FOREFOOT EXTENSIONS	
<p>TYPE</p> <input type="checkbox"/> Standard <input type="checkbox"/> Spot Grind <input type="checkbox"/> Strip <input type="checkbox"/> Hole	<p>LENGTH</p> <input type="checkbox"/> Toes <input type="checkbox"/> Sulcus <input type="checkbox"/> Mets	<p>GLUING</p> <input type="checkbox"/> Glue All <input type="checkbox"/> Glue Posterior Half <input type="checkbox"/> Glue Heel Only	<p>LENGTH <input type="checkbox"/> R <input type="checkbox"/> L</p> <input type="checkbox"/> Toes <input type="checkbox"/> Sulcus <input type="checkbox"/> Beveled on Device	<p>MATERIAL</p> <input type="checkbox"/> Poron <input type="checkbox"/> Korex <input type="checkbox"/> EVA <input type="checkbox"/> Soft <input type="checkbox"/> Firm
<p>MOTION</p> <input type="checkbox"/> 0/0 <input type="checkbox"/> 4/4	<p>MATERIAL</p> <input type="checkbox"/> 3mm Soft EVA (tricolor) <input type="checkbox"/> 3mm Soft EVA (black) <input type="checkbox"/> 3mm Firm EVA (black) <input type="checkbox"/> Diabetic (leather / P-cell™ / Poron®) <input type="checkbox"/> Leather (black) <input type="checkbox"/> Nylene <input type="checkbox"/> 1.5mm <input type="checkbox"/> 3mm <input type="checkbox"/> Sport <input type="checkbox"/> Vinyl		<p>THICKNESS</p> <input type="checkbox"/> 1.5mm <input type="checkbox"/> 3mm <input type="checkbox"/> 5mm <input type="checkbox"/> 6mm	<p>ADD</p> <input type="checkbox"/> Slot (mark on diagram) <input type="checkbox"/> Punch (mark on diagram) <input type="checkbox"/> Valgus Extension _____° R _____° L <input type="checkbox"/> Varus Extension _____° R _____° L <input type="checkbox"/> Rev. Morton's Extension <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Morton's Extension <input type="checkbox"/> R <input type="checkbox"/> L
<p>MATERIAL</p> <input type="checkbox"/> EVA <input type="checkbox"/> Polypropylene			<p>Unweight met heads #:</p> <p>_____ R _____ L</p>	
<p>BEVEL (Do not bevel post...)</p> <p>Medially <input type="checkbox"/> R <input type="checkbox"/> L Laterally <input type="checkbox"/> R <input type="checkbox"/> L</p>	<p><input type="checkbox"/> Add Poron under topcover <input type="checkbox"/> 1.5mm <input type="checkbox"/> 3mm</p> <p><input type="checkbox"/> Bottom Cover (vinyl)</p>			

SPECIAL ADDITIONS

Arch Pad R L
 EVA Arch Fill R L
 Medium
 Firm
 Heel Lift _____ mm R _____ mm L
 Taper lift to mets (requires EVA fill)
 Heel Pad R L
 Horseshoe Pad R L
 Metatarsal Pad R L
 Metatarsal Bar R L
 Neuroma Pad R L
 _____ Interspace
 Toe Filler (must send shoes) R L

SPECIAL INSTRUCTIONS – Extra charges may apply

Adjust (within 90 days of original order)
 Refurbish as before Refurbish as prescribed above

Doctor's Signature (required) _____

ORDER PROCESSING RUSH – 1 day in lab
 (Rush items ship overnight) RUSH – 3 day in lab

SPECIAL SHIPPING FedEx Overnight
 FedEx Ground
 Ship to Patient

REORDERS

(Fax reorders to 707-257-4420)

Exactly as before
 As prescribed above

Image # _____
 (Reference number from bottom of orthotics)