

NAME OF PATIENT: _____	CONTACT PHONE: _____
PO #: _____ TODAY'S DATE: _____	REQUESTED BY DATE: _____
CLINIC NAME: _____	PRACTITIONER'S NAME: _____
SHIP TO ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____	
SHIP VIA UPS: GROUND / 3DAY / 2DAYAM / 2ND DAY / NEXT DAY / NDS / NDAM	SHIPPER ID: _____

PATIENT AGE: _____ M / F	HEIGHT: _____ WT: _____
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LEATHER GAUNTLET

CLOSURE: LACE _____ VELCRO _____ COMBO _____

COLOR: NEUTRAL _____ BLACK _____ BROWN: _____ WHITE: _____

NEGATIVE CAST CORRECTION:

AS IS: _____ NEUTRAL: _____

90° LOWBOARD: _____

90° TO FLOOR: _____

UNLOADED: _____

OTHER: _____

INNER PLASTIC TRIM LINES:

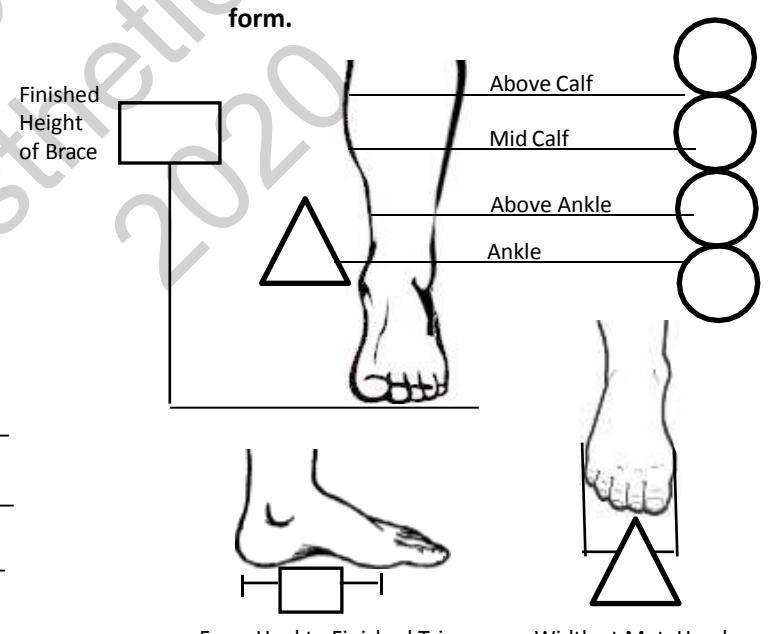
HEEL CUT OUT: _____ SOLID: _____

OTHER: _____

REMARKS: _____

LEFT SHOE _____ or RIGHT SHOE _____

Please make sure to mark any problem areas or other important information on the cast and the order form.



Finished Height of Brace

Above Calf

Mid Calf

Above Ankle

Ankle

From Heel to Finished Trim

Width at Met. Head