

CUSTOM ORTHOTIC RX FORM

Account # _____ P.O. #: _____
 Account Name _____
 Practitioner Name _____
 Phone _____ Fax _____
 Email _____
 Street Address _____
 City/St/Zip/Postal Code _____
 Recast from previous order
 Serial # _____
 5-Day Rush - (\$25 Fee)

LAB USE ONLY
 Serial # _____
 Opened By _____ Incoming Postage _____
 Date Received _____

Patient's Name _____
 Street Address _____
 City/St/Zip/Postal Code _____
 Telephone () _____
 Sex M F Age _____ Height _____ Weight _____
 Shoe Size _____
 PUMP Flat Low heel High heel
 LACED Low volume interior High volume interior
 Athletic Safety boots Other _____

This is a prepaid order
 Check enclosed Check# _____ Money order enclosed Check# _____
 Charge to: Mastercard VISA AmEx Discover # _____
 Expiration Date _____ Signature _____

Protect® Program Serial # _____ Repair Outgrow Loss ****Attach copy of patient's Protect Agreement****

SPORTHOTICS

ALLSPORT (To metatarsals) MARATHONER (To sulcus) HEALTHFLEX® (To toes) SOCCER (To sulcus)
 ALLSPORT FLEXIBLE (To metatarsals) SPRINTER (To toes) BASKETBALL (To toes)

FASHION DEVICES

SLIMTHOTICS® (To sulcus)
 Extension width 1st to 3rd metatarsal heads
 Extension width 1st to 5th metatarsal heads
 Full width forefoot shell 1st to 5th metatarsal heads with
 1/16" PPT® extension
 DESIGNLINE® (To sulcus)
 SUPERFORM STYLOTIC® (To sulcus)

CONTROLLING/FUNCTIONAL DEVICES

LYTE FIT® (To metatarsals) U.C.B.L. (To metatarsals)
 HEEL FIT® Firm (to toes) D.S.I.S. (To metatarsals)
 HEEL FIT® Flexible (to toes)

ACCOMMODATIVE DEVICES

BLUELINE (To sulcus)
 Available fillers Foam (soft) EVA (medium) Thermocork (firm)
 RUNNER'S MOULD (To sulcus)
 LEATHER MOULD (To sulcus)
 Available fillers Foam (soft) EVA (medium) Thermocork (firm)

THERACARE DEVICES

SOFT (To toes) FIRM (To toes)

CUSTOM ORTHOTIC RX FORM

EXAMINATION FINDINGS

1st Ray Position
R Plantarflexed L
(1st ray cut out)
R Normal L
R Dorsiflexed L

General Foot Motions
R Restricted L
R Average L
R Loose L

Location of Corns/Calluses
R _____ L _____

Foot Appearance (non-weight bearing)
R High arch L
R Medium arch L
R Low arch L

Ankle Dorsiflexion
R Adequate L
R Limited L

Subtalar Joint Motion
R Restricted L
R Average L
R Loose L

Forefoot
_____ ° Varus _____ ° Varus
_____ ° Valgus _____ ° Valgus

Hallux Dorsiflexion
R Rigid L
R Semi-Rigid L
R Normal L

Limb Length Differences
Right limb shorter by _____ mm/in
Left limb shorter by _____ mm/in

Foot Appearance (weight bearing)
R High arch L
R Medium arch L
R Low arch L

Knee Position
 Genu Varum Norm Genu Valgum

Gait Pattern
 In Toe Norm Out Toe
R _____ ° Subtalar Inversion L _____ °
R _____ ° Subtalar Eversion L _____ °
R _____ ° Subtalar Neutral L _____ °
R _____ ° Rested Calcaneal Stance
Tibial Varus
R _____ ° L _____ °

POSTING VALUES

Post according to lab evaluation of data and cast
 DO NOT post the rearfoot and/or forefoot
Post to these values instead

RIGHT LEFT
REARFOOT _____ ° Varus _____ ° Varus
 Intrinsic Extrinsic (unless stated otherwise)

RIGHT LEFT
FOREFOOT _____ ° Varus _____ ° Varus
_____ ° Valgus _____ ° Valgus
 Intrinsic Extrinsic

Any forefoot post over 5° will be split intrinsic and extrinsic.
 1-5 Post Bar 2-5 Post Bar w/ 1st Ray Cutout
 Compressible forefoot post to sulcus Tip Post

HEEL LIFT* _____ " mm/in _____ " mm/in
Heel lifts will be sent separately when rearfoot is posted intrinsically

FOREFOOT EXTENSIONS

From Distal End of Shell To
 Sulcus Toes
Thickness
 1/8" 1/16"
Materials
 PPT PLASTAZOTE®
 PPT/PLASTAZOTE® (3/16" ONLY)

PADDED TOPCOVERS

Cover From Heel To
 Mets Sulcus Toes
Thickness
 1/8" 1/16"
Materials
 PPT PLASTAZOTE®
 PPT/PLASTAZOTE® (3/16" ONLY)

SPECIAL COVERING REQUESTS

BambooLon 1/8" 1/16" Medium Density EVA
 Neoprene 1/8" 1/16" 1/8" 1/16"
 1/8" Slow Recovery PPT w/ 1/16" PPT Glove leather Black Tan
 Mets Sulcus Toes Perforated glove leather
 Ucolite 1/8" 1/16" Suede bottom cover
 Blue Black Jazz Blue Black
 Suede top cover
 Jazz Blue Black

DIAGNOSIS/CHIEF COMPLAINT/SPECIAL INSTRUCTIONS

SHELL MODIFICATIONS/SUBSTITUTIONS

<input type="checkbox"/> Deep Heel Seat	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Cut Orthoses Narrow
<input type="checkbox"/> Lateral Flange	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Gait Plate to promote
<input type="checkbox"/> Medial Flange	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Out toe <input type="checkbox"/> In toe
<input type="checkbox"/> Reduce Bulk	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> SUPERFORM®
<input type="checkbox"/> Lateral Clip	<input type="checkbox"/> R	<input type="checkbox"/> L	<input type="checkbox"/> Kirby Skive _____ mm
<input type="checkbox"/> Morton's ext to shell	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> 1st Ray Cut Out	<input type="checkbox"/> R	<input type="checkbox"/> L	
<input type="checkbox"/> Kinetic Wedge	<input type="checkbox"/> R	<input type="checkbox"/> L	

SPECIAL PADDINGS/ACCOMMODATIONS

Arch Reinforcement (Standard for patients 275lbs. + excluding Superform Stylotic)

<input type="checkbox"/> Foam	<input type="checkbox"/> EVA	<input type="checkbox"/> Thermocork	
			Right Left
Heel spur pad	<input type="checkbox"/>	<input type="checkbox"/>	Neuroma pad <input type="checkbox"/>
Heel cushion	<input type="checkbox"/>	<input type="checkbox"/>	3rd interspace unless specified
2-4 Met pad	<input type="checkbox"/>	<input type="checkbox"/>	Neuroma plug <input type="checkbox"/>
Met bar pad	<input type="checkbox"/>	<input type="checkbox"/>	Interspace
Toe crest pad	<input type="checkbox"/>	<input type="checkbox"/>	Dancer's pad <input type="checkbox"/>
Scaphoid pad	<input type="checkbox"/>	<input type="checkbox"/>	Morton's ext. <input type="checkbox"/>

Buttress pad (Right) please circle 1 2 3 4 5 (or mark on diagram)
Balance pad (Right) please circle 1 2 3 4 5 (or mark on diagram)

Buttress pad (Left) please circle 1 2 3 4 5 (or mark on diagram)
Balance pad (Left) please circle 1 2 3 4 5 (or mark on diagram)

