Langer Biomechanics
An OHI Company

QUALITY INNOVATION EDUCATION
WWW.LANGERBIOMECHANICS.COM

FIRST CHOICE ORTHOTIC RX

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 _____
LACED ☐Low volume interior ☐High volume interior
☐Athletic ☐Safety boots ☐Other _____

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

1 ORTHOTICS
Choose one device with standard topcover

- ☐ FirstChoice Accommodative (1/16" Black Starsuede Topcover to Sulcus)
- ☐ FirstChoice Sport (1/8" Blue ETC Topcover to metatarsals)
- ☐ FirstChoice Composite (1/8" Blue ETC to metatarsals)
- ☐ FirstChoice Dress (Black Vinyl to sulcus)
- ☐ FirstChoice Semi-Flex (1/16" Black Starsuede to toes)
- ☐ FirstChoice Pediatric (1/16" Black Starsuede to metatarsals)

2 SPECIAL COVERING REQUESTS (OPTIONAL)
Choose one alternate topcover to replace standard topcover

1/8" Blue ETC	☐	3/16" Plastazote	☐
3/16" Blue ETC (extra padding)	☐	1/8" Multicolor EVA	☐
1/16" Black Starsuede	☐	1/16" Multicolor EVA	☐
3/16" Black Starsuede (extra padding)	☐	1/8" Neoprene	☐
Black Vinyl (no padding)	☐	1/16" Neoprene	☐

☐ To Metatarsal ☐ To Sulcus ☐ To Toes

3 ADDITIONS AND MODIFICATIONS

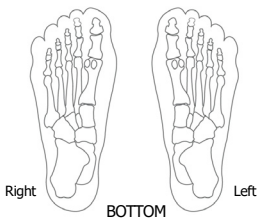
	Right	Left
Heel Spur Balance	☐	☐
Heel Cushion	☐	☐
Heel lift 1/8"	☐	☐
Heel lift 3/16"	☐	☐
Heel lift 1/4"	☐	☐
1st Ray Cut Out	☐	☐
Hole in Heel ☐include Foam Disk	☐	☐
Medial Flange	☐	☐
Lateral Flange	☐	☐
Morton's Extension	☐	☐
Reverse Morton's Extension	☐	☐
Neuroma Pad	☐	☐
3rd interspace unless specified _____		
Neuroma Plug	☐	☐
Interspace _____		
Metatarsal Pad	☐	☐
Metatarsal Bar	☐	☐
Scaphoid Pad	☐	☐
Balance Pad Right (please circle)	1 2 3 4 5	
Balance Pad Left (please circle)	1 2 3 4 5	
Deep Heel Seat	☐	☐
Gait Plate to promote (Pediatric Only)	☐ in toe	☐ out toe

4 POSTING VALUES

	Right	Left
Forefoot Intrinsic	_____ Varus	_____ Varus
	_____ Valgus	_____ Valgus
Forefoot Extrinsic	_____ Varus	_____ Varus
	_____ Valgus	_____ Valgus
Rearfoot Intrinsic	_____ Varus	_____ Varus
Rearfoot Extrinsic	_____ Varus	_____ Varus

Plantar View

PLEASE MARK ALL CASTS and the illustration to the right to ensure proper placement of accommodations.



DIAGNOSIS/CHIEF COMPLAINT/SPECIAL INSTRUCTIONS

_____
_____
_____
_____

For Canadian Customers ship to:
160 Markland Street
Markham, ON L6C 0C6
T: 877.644.4344
F: 866.538.9472

For U.S Customers ship to:
Purolator – Langer Northbound Consolidation
C/O Orthotic Holdings
25801 Northline Com Dr.
Taylor, MI 48180

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