

FIBER

ORTHOTICS

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SEND TWO COPIES TO LAB
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CUSTOM ORTHOTIC ORDER FORM

DR. CODE

Dr. Name _____ Dr. Phone () _____

Address _____

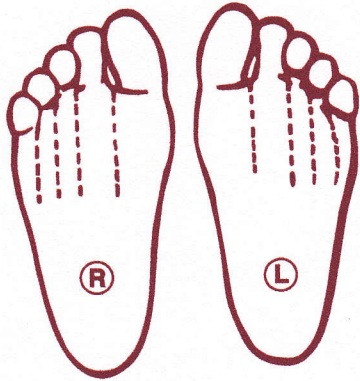
Patient _____ Age _____ Sex _____ Wt. _____ Ht. _____

Type of shoe worn most _____ Chief Complaint _____ Your Diagnosis _____

Shoe size _____ width _____

Occupation _____

Type of sport activity _____

<p>TYPE OF ORTHOTIC</p> <p><input type="checkbox"/> Sport <input type="checkbox"/> Flexible</p> <p><input type="checkbox"/> Dress Flat <input type="checkbox"/> Women's Dress <input type="checkbox"/> Men's Dress <input type="checkbox"/> Special Dress <i>width of forefoot shell</i> 1 2 3 4 5</p> <p><input type="checkbox"/> Very Thin Dress</p> <p><input type="checkbox"/> TL - Graphite</p> <p><input type="checkbox"/> Child <input type="checkbox"/> Gait - Plate (to correct) <input type="checkbox"/> in toe <input type="checkbox"/> out-toe</p> <p><input type="checkbox"/> Support Accommodative <input type="checkbox"/> plastic & pelite <input type="checkbox"/> plastic & neoprene <input type="checkbox"/> plastic & cork</p> <p><input type="checkbox"/> Accommodative Cork & Leather <input type="checkbox"/> to met heads <input type="checkbox"/> to the sulcus <input type="checkbox"/> full length</p> <p><input type="checkbox"/> Tri- Density <input type="checkbox"/> soft base <input type="checkbox"/> rigid base 4 oz. Cowhide Leather <input type="checkbox"/> Yes <input type="checkbox"/> No Middle Absorbafoam Layer <input type="checkbox"/> 1/16 <input type="checkbox"/> 1/8 <input type="checkbox"/> 3/16 <input type="checkbox"/> 1/4 Top Layer *Use Extensions & Top Cover</p> <p><input type="checkbox"/> Diabetic Mold</p>	<p>EXTENSIONS & TOP COVER</p> <p><input type="checkbox"/> Absorbafoam <input type="checkbox"/> Spenco <input type="checkbox"/> Pelite <input type="checkbox"/> P-Cell <input type="checkbox"/> Plastazote <input type="checkbox"/> Puff <input type="checkbox"/> 1/16 <input type="checkbox"/> 1/8 <input type="checkbox"/> 3/16</p> <p>Start Extension <input type="checkbox"/> from heel <input type="checkbox"/> from end of shell</p> <p>Length <input type="checkbox"/> over shell <input type="checkbox"/> 3/4 sulcus <input type="checkbox"/> full length</p> <p>POSTING</p> <p><input type="checkbox"/> Post According to Positive Model <input type="checkbox"/> Rearfoot <input type="checkbox"/> Intrinsic right ___° Varus <input type="checkbox"/> left ___° Varus <input type="checkbox"/> Valgus <input type="checkbox"/> Valgus <input type="checkbox"/></p> <p><input type="checkbox"/> Forefoot <input type="checkbox"/> Intrinsic right ___° Varus <input type="checkbox"/> left ___° Varus <input type="checkbox"/> Valgus <input type="checkbox"/> Valgus <input type="checkbox"/></p> <p><input type="checkbox"/> Forefoot Tip right ___° Varus <input type="checkbox"/> left ___° Varus <input type="checkbox"/> Valgus <input type="checkbox"/> Valgus <input type="checkbox"/></p> <p>ADDITIONS & ACCOMMODATIONS</p> <p><input type="checkbox"/> Keep ___ narrow ___ med ___ wide <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> First Ray Cut - Out <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Deep heel cup <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Lateral flange or clip <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Medial flange <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Reinforce L.A. <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Heel Spur (as marked on cast) <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p>	<p><input type="checkbox"/> U Pad in heel <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Met Pad ___ low ___ med. ___ high <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Neuroma pad (as marked on cast and diagram) <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Morton Extension <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Crest <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Padding in L.A. <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Padding in heel <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <p><input type="checkbox"/> Balance for lesions (as marked on cast and diagram) <input type="checkbox"/> right <input type="checkbox"/> left <input type="checkbox"/> both</p> <div style="text-align: center;">  </div> <p>Mark Lesions & neuroma pain for balancing <input type="checkbox"/> Build up for shortness of limb</p> <p>_____ right _____ left</p>
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SEE BACK FOR ADDITIONAL INFORMATION