

Patient Information (PLEASE PRINT)

Name: _____
Occupation: _____

Sex _____ Age _____ Ht. _____ Wt. _____

Chief Complaint (include pain, type, location, duration)

Doctor Information

Name: _____
Address: _____







Phone: () _____

Your Diagnosis

Posting Instructions:	Post to lab values <input type="checkbox"/>	Post to forefoot intrinsic <input type="checkbox"/>	Post to these values <input type="checkbox"/>
Forefoot: Right _____	Varus <input type="checkbox"/>	Valgus <input type="checkbox"/>	Left _____
Rearfoot: Right _____	Varus <input type="checkbox"/>	Valgus <input type="checkbox"/>	Left _____
2-5 Bar <input type="checkbox"/>	First Ray Cut Out <input type="checkbox"/>	First Met Cut Out <input type="checkbox"/>	Right <input type="checkbox"/> Left <input type="checkbox"/>
Medial Heel Skive	Right _____ mm	Left _____ mm	

Type of Orthotic	Gait Plate - to force toe out <input type="checkbox"/>	Robert Whitman Plate <input type="checkbox"/>	Shaffer Plate <input type="checkbox"/>	UCBL <input type="checkbox"/>
COL Sports	Standard <input type="checkbox"/>	Tennis, Racquet Ball <input type="checkbox"/>	Aerobics <input type="checkbox"/>	Impact <input type="checkbox"/> Skiing, Skate <input type="checkbox"/>
COL Flex	Standard (Firm control) <input type="checkbox"/>	Flex III (Mild control) <input type="checkbox"/>	Flex V (Intrinsic Forefoot & Rearfoot Posting) <input type="checkbox"/>	
COL Ultraflex	Ultraflex Dress Orthotic <input type="checkbox"/>	Ultraflex Standard Orthotic <input type="checkbox"/>	Ultraflex Rigid Orthotic <input type="checkbox"/>	
COL TL-61 (Graphite) (can not have deep heel)	Regular Orthotic w/SBR Rubber Posting <input type="checkbox"/>	TL-61 Ladies Dress Orthotic <input type="checkbox"/>		
Accommodative molds	Heel Spur Orthotic <input type="checkbox"/>	Evalyte <input type="checkbox"/>	Korex <input type="checkbox"/>	Evalyte only (very soft) <input type="checkbox"/> Plastazote <input type="checkbox"/>

Additions and Extensions	To Met Heads <input type="checkbox"/>	Evalyte w/vinyl 1/16" <input type="checkbox"/> 1/8" <input type="checkbox"/>	Poron™ w/vinyl 1/16" <input type="checkbox"/> 1/8" <input type="checkbox"/>	Nyplex w/vinyl 1/8" Black <input type="checkbox"/>
Covers	To Sulcus <input type="checkbox"/>	Microcell Puff Black 1/16" <input type="checkbox"/>	Sport EVA 1/8" <input type="checkbox"/>	Doeskin Black 1/8" <input type="checkbox"/> ETC Black 1/8" <input type="checkbox"/>
	Full <input type="checkbox"/>	Spenco (Blue <input type="checkbox"/> Green <input type="checkbox"/> Black <input type="checkbox"/>)	Vinyl (Black <input type="checkbox"/> White <input type="checkbox"/> Ash Grey <input type="checkbox"/> Honey <input type="checkbox"/>)	Leather <input type="checkbox"/> Suede <input type="checkbox"/>
Forefoot Extensions only	Plastazote <input type="checkbox"/>	Evalyte/ 1/16" <input type="checkbox"/> 1/8" <input type="checkbox"/>	Poron™ 1/16" <input type="checkbox"/> 1/8" <input type="checkbox"/>	To Sulcus <input type="checkbox"/> Full <input type="checkbox"/>
Arch Reinforcements	Korex <input type="checkbox"/>	Evalyte <input type="checkbox"/>	Vinyl Underlay <input type="checkbox"/>	
Additions	Deep Heel Seat 18mm <input type="checkbox"/> _____ mm <input type="checkbox"/>	Heel Raise R/L <input type="checkbox"/>	1/16" <input type="checkbox"/>	Lateral Clip <input type="checkbox"/>
				1/8" <input type="checkbox"/> 1/4" maximum <input type="checkbox"/>

Accommodate lesions as marked <input type="checkbox"/>	Met Pad R/L <input type="checkbox"/>	Small <input type="checkbox"/>	Medium <input type="checkbox"/>	Large <input type="checkbox"/>
 <p>Right Left</p>	Heel Cushion only			Left <input type="checkbox"/> Right <input type="checkbox"/>
	Heel Cushion with Centre Pocket			Left <input type="checkbox"/> Right <input type="checkbox"/>
	Horseshoe Heel Cushion			Left <input type="checkbox"/> Right <input type="checkbox"/>
	Morton's Extension			Left <input type="checkbox"/> Right <input type="checkbox"/>
	Reverse Morton's Extension			Left <input type="checkbox"/> Right <input type="checkbox"/>
Grinding Width Preferred	Narrow <input type="checkbox"/>	Normal <input type="checkbox"/>	Wide <input type="checkbox"/>	Medial Flange <input type="checkbox"/>
				Fit To Shoe <input type="checkbox"/> Shoe Size _____

Please send me Casting Foam Labels Order Forms

Additional Comments or Instructions

For Lab Use Only:	Right	Left
FFT Measured	_____	_____
FFT Posted	_____	_____
RFT Posted	_____	_____
Medial Skive	_____	_____