Date Recieved _____ Handling _____

American Orthotics™

SAINT LOUIS MISSOURI

P. Time _____ Tech. _____

P.O BOX 9174 ST. LOUIS, MISSOURI 63117 (314) 781-9900 800-644-3579 www.americanorthotics.com

CUSTOM PRESCRIPTION ORDER FORM (PLEASE INCLUDE ALL PATIENT INFORMATION REQUESTED)

Account Name _____ **Patient Name** _____

Address _____ Age____ Weight_____ Sex____ Shoe Size_____

City_____State_____ Occupation _____

Phone ( ) _____Zip_____ [ ] Store Casts Five Months

Doctor's Signature _____ [ ] Return Positive Casts and Charge Account

ORTHOTIC TYPE

[ ] SPORTS ORTHOTIC
[ ] REFLEX PIVOT SPORTS ORTHOTIC
[ ] THE SHOCK ABSORBER
[ ] ACTIVE SENIORS ORTHOTIC
[ ] THE SHARK
[ ] MEN'S TL
[ ] WOMEN'S TL
[ ] WOMEN'S FASHION FLEX...Flats & Pumps
[ ] **WOMEN'S FASHION ORTHOTIC w/o HEEL CUP
**SEND HIGH HEEL SHOES

[ ] THE "COBRA"
[ ] NEOZOTE INSOLES____1/4"____1/8"
[ ] MOLDED PLASTAZOTE POURON INSOLES
[ ] DIABACCOM to SULCUS ____FULL____
[ ] UCBL TYPE ORTHOTIC
[ ] GAIT PLATE TO CORRECT IN TOE
[ ] HEEL STABILIZER MEDIAL FLANGE
[ ] HEEL STABILIZER LATERAL FLANGE
[ ] ORTHOTIC FOR 1ST MPJ, DJD OR IMPLANT
__ LEFT __ RIGHT

CASTING TECHNIQUE:
___ Non Weight Bearing
___ Semi Weight Bearing
___ Full Weight Bearing

HEEL SEAT:
___ Minimal Heel Seat
___ Standard Heel Cup
___ Deep Heel Cup

ORTHOTIC WIDTH:
___ Narrow for Dress Shoes
___ Normal for Most Shoes
___ Wide for X-Depth Shoes

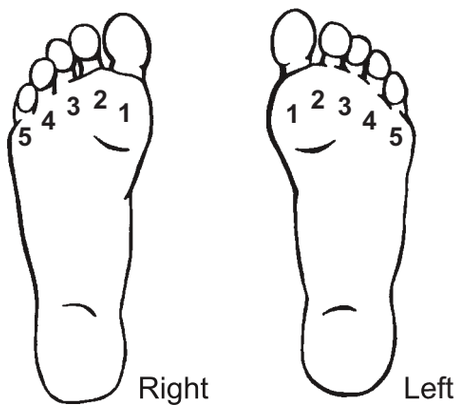
POSTING: ___ No Posting ___ Post 0° ___ Post to Vertical ___ Post per Rx ___ Post at Lab Discretion

EXTRINSIC:	**Left**	**Right**
Rearfoot	___°Varus	___°Varus
	___°Valgus	___°Valgus
Forefoot	___°Varus	___°Varus
	___°Valgus	___°Valgus

INTRINSIC:	**Left**	**Right**
Rearfoot	___°Varus	___°Varus
	___°Valgus	___°Valgus
Forefoot	___°Varus	___°Varus
	___°Valgus	___°Valgus

ACCOMMODATIONS:

___ Metatarsal Depression *Please indicate on diagram
___ Metatarsal Raise *Please indicate on diagram
___ Neuroma *Please indicate on diagram
___ Capsulitis *Please indicate on diagram
___ IPK *Please indicate on diagram
___ Toe Fill *Please indicate on diagram
___ Cuboid Pad *Please indicate on diagram
___ Cut Out 1st Ray *Please indicate on diagram
___ Porokeratosis *Please indicate in cast
___ Plantar Fibroma *Please indicate in cast
___ Load 1st Metatarsal Left ___ Right ___
___ Sesamoiditis or Fx Left ___ Right ___
___ Hallux Limitus Funct Left ___ Right ___
___ Heel Spur Pad Left ___ Right ___
___ Heel Elevation Left ___" Right ___"
Pouron Extension ___ 1⁄16" ___ 1⁄8" ___ Sulcus ___ Full
Pouron Cover/Vinyl ___ 1⁄16" ___ 1⁄8" ___ Shell Only ___ Sulcus ___ Full
Neolon Cover ___ 1⁄16" ___ 1⁄8" ___ Shell Only ___ Sulcus ___ Full
Leather Cover ___ Shell Only ___ Sulcus ___ Full ___Suede ___Calf



Diagnosis, Comments, Instructions:

_____
_____
_____
_____

[ ] Please Send More Order Forms [ ] Please Send More Shipping Boxes

1/09