

DEVICE SERIAL No.

ORTHOSIS PRESCRIPTION FORM FOR THE PRACTITIONER REQUIRING EVALUATION ASSISTANCE

Send top copy to Lab. Retain bottom copy

1. PATIENT DATA

Surname..... First Name.....
 Age..... Sex..... Weight..... Height..... Occupation.....

PRACTITIONER

Account Name..... Account No..... V.I.P. Y/N
 Address.....
 Post Code..... Tel. No.....

2. ORDER TYPE 1st Prescription Repeat Protect Repair Guarantee

3. SHOE DATA Wide Broad Fitting - Oxford High Heel Narrow Slip-on Loafer Trainer Sports Shoe

4. PATIENT HISTORY Chief Complaint

5. DEVICE TYPE REQUIRED To Mets To Sulcus

6

Please use diagram to indicate where accommodations are needed.
 Mark lesions on your cast with felt tip pen

MEASUREMENTS

Subtalar Joint:	LEFT	RIGHT
Subtalar Inversion	_____ °	_____ °
Subtalar Eversion	_____ °	_____ °

A. Subtalar Neutral: _____ ° Varus _____ ° Varus

B. Forefoot: _____ ° Varus _____ ° Varus
 _____ ° Valgus _____ ° Valgus

C. Tibial Varum: _____ ° Varus _____ ° Varus
 Valgum _____ ° Valgus _____ ° Valgus

D. Neutral Calcaneal Stance: _____ ° Varus _____ ° Varus
 A+C=D _____ ° Valgus _____ ° Valgus

Relaxed Calcaneal Stance: _____ ° Varus _____ ° Varus
 _____ ° Valgus _____ ° Valgus

7A EXAMINATION FINDINGS

Ankle Dorsiflexion:

3 - 6°	<input type="checkbox"/>	<input type="checkbox"/>
7 - 9°	<input type="checkbox"/>	<input type="checkbox"/>
10° and more	<input type="checkbox"/>	<input type="checkbox"/>

1st Ray Position:

Plantarflexed	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>
Dorsiflexed	<input type="checkbox"/>	<input type="checkbox"/>

Hallux Dorsiflexion:

Rigidus	<input type="checkbox"/>	<input type="checkbox"/>
Limitus	<input type="checkbox"/>	<input type="checkbox"/>
Average	<input type="checkbox"/>	<input type="checkbox"/>

Limb Length Difference:
 Right limb is shorter by _____ mm
 Left limb is shorter by _____ mm

Location of corns/callouses: L _____
 R _____

	LEFT	RIGHT
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General Foot Motions:

Restricted	<input type="checkbox"/>	<input type="checkbox"/>
Average	<input type="checkbox"/>	<input type="checkbox"/>
Loose	<input type="checkbox"/>	<input type="checkbox"/>

Toe Positions:

Straight	<input type="checkbox"/>	<input type="checkbox"/>
Subluxed	<input type="checkbox"/>	<input type="checkbox"/>
Contracted	<input type="checkbox"/>	<input type="checkbox"/>
HAV	<input type="checkbox"/>	<input type="checkbox"/>

1st Metatarsal Segment:

Rigid	<input type="checkbox"/>	<input type="checkbox"/>
Semi-rigid	<input type="checkbox"/>	<input type="checkbox"/>
Flexible	<input type="checkbox"/>	<input type="checkbox"/>

Knee Positions:

<input type="checkbox"/> Bowlegged	<input type="checkbox"/> Straight	<input type="checkbox"/> Knock Knee
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Gait Pattern:

<input type="checkbox"/> In-toe	<input type="checkbox"/> Straight	<input type="checkbox"/> Out-toe
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Patient had previous treatment with orthoses? Y N

ADDITIONAL INSTRUCTIONS.....

