



FOR PRACTITIONERS WRITING THEIR OWN PRESCRIPTION

PATIENT DATA

PLEASE NOTE:- ONLY ONE PRESCRIPTION PER ORDER

Surname..... First Name..... Date of Birth..... Weight.....

PRACTITIONER (Required Information)

Account Name..... Account No..... Practitioner.....

Address.....

Post Code..... Tel. No..... Email Address.....

PLEASE NOTE - THE SHADED SECTION BELOW MUST BE FILLED IN BY THE PRACTITIONER OR THE PRESCRIPTION WILL NOT BE PROCESSED

ORDER TYPE	DEVICE TYPE REQUIRED	REARFOOT		FOREFOOT				
Guarantee <input type="checkbox"/>		<input type="checkbox"/> Intrinsic	<input type="checkbox"/> Extrinsic	<input type="checkbox"/> No Post	<input type="checkbox"/> Intrinsic	<input type="checkbox"/> Extrinsic	<input type="checkbox"/> Root	<input type="checkbox"/> Sulcus
1st Prescription <input type="checkbox"/>		LEFT	VARUS	°	LEFT	VARUS	°	VALGUS
Repeat <input type="checkbox"/>	CODE.....	RIGHT	VARUS	°	RIGHT	VARUS	°	VALGUS
<input type="checkbox"/>	Cover to:— Mets/Sulc./Toes	POSTING MATERIAL DENSITY	HIGH <input type="checkbox"/>	MEDIUM <input type="checkbox"/>	LOW <input type="checkbox"/>			
SHOE TYPE	Wide Broad Fitting - Oxford <input type="checkbox"/>	High Heel <input type="checkbox"/>	Narrow Slip-on Loafer <input type="checkbox"/>	Trainer Sports Shoe <input type="checkbox"/>				

	LEFT	RIGHT
Medial Addition	None/Average/Deep	None/Average/Deep
Lateral Expansion	None/Average/Wide	None/Average/Wide
Kirby Skivemmmm
2-5 Bar post with first ray cut out	<input type="checkbox"/>	<input type="checkbox"/>
Heel raisemmmm
	Heel cup height	
Standard	<input type="checkbox"/>	<input type="checkbox"/>
Deep	<input type="checkbox"/>	<input type="checkbox"/>
Othermmmm
	(Devices cannot be cut narrow with deep heel seat)	

SHELL SPECIFICATION	LEFT	RIGHT
High Medial Flange	<input type="checkbox"/>	<input type="checkbox"/>
Lateral Flange	<input type="checkbox"/>	<input type="checkbox"/>
1st Ray Cut Out	<input type="checkbox"/>	<input type="checkbox"/>
1st Met Cut Out	<input type="checkbox"/>	<input type="checkbox"/>
Cut Orthoses Narrow	<input type="checkbox"/>	<input type="checkbox"/>

Heel Height of Shoe..... *Please subtract height of sole*

Fill Arch Under Orthotic	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>
Density	High <input type="checkbox"/>	Medium <input type="checkbox"/>	Low <input type="checkbox"/>

SPECIAL PADDING INSTRUCTIONS

Heel Pad	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>
Heel Spur Pad	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>
Metatarsal Pad	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>
Metatarsal Bar	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>
Valgus Pad	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>
Mortons Extension	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>
Balance Pad	Left <input type="checkbox"/>	Right <input type="checkbox"/>	Both <input type="checkbox"/>

IF YOU REQUIRE BALANCE PADS PLEASE MARK LESIONS ON YOUR CAST WITH A FELT TIP PEN

ADDITIONAL INSTRUCTIONS

**ROYAL MAIL 1st CLASS (STD)
GUARANTEED NEXT DAY
DELIVERY (£5.50)**

DELIVERY SCHEDULE

Standard 12 Working Days *Please sign and initial for Express Delivery costs*

5 Working Days (£16.45) INC VAT

2 Working Days (£29.08) INC VAT

NOTE

THIS PRESCRIPTION IS USED AS A DIRECT WORK INSTRUCTION AND WILL BE FOLLOWED EXACTLY. LAB. DEFAULTS WILL BE USED WHERE DETAILS ARE OMITTED

PLEASE FORWARD

Protect Information

Casting Chart

More Prescriptions

Multi Cast Boxes

Product Catalogue

Single Cast Boxes

Langer (UK) Ltd.
 Brookhouse Way, Cheadle, Stoke-on-Trent ST10 1SR
 Tel: 01538 755861 Fax: 01538 755862
 Email: evaluation@lbguk.com
 Web: www.lbguk.com