

# Orthotic Order Form



Date: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_  
 Shoe Size: \_\_\_\_\_ M / F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Medical Condition(s): \_\_\_\_\_  
 Primary Complaint(s): \_\_\_\_\_  
 Clinic Name: \_\_\_\_\_ Clinician: \_\_\_\_\_

Notes:

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## Orthotic Prescription

Base Shell			
Subortholen or Polypro			Other(Detail Below) _____
2mm	3mm	4mm	

* Heel Raise *	
_____mm	Right / Left / Bilateral

Heel Post		
Neutral	Valgus _____ Deg	Varus _____ Deg

* Heel Window *
Right / Left / Bilateral

Heel Cup		
Standard	Shallow	Deep

Top Padding		
SL	SLW	2mm Cork

* Metatarsal Pad *
Right / Left / Bilateral

* Specialized Padding *		
Diabetic	Leather (Brown)	Reboflex (P-Cell)

* Morton's Extension *
Right / Left / Bilateral

* 2-5 Bar / 2-4 Bar *
Right / Left / Bilateral