

REFERRAL INFO:

Name: _____ Case #: _____

Store Casts ☐

Date: _____

PATIENT/BILLING INFO:

Office Phone: _____

Patient Name: _____

Last First Middle Initial Email Address

Parent Name: _____

(If Minor):

Last First Middle Initial Cell Phone Email Address

Address: _____

Street City State Zip

Home Phone: () Work Phone: () Cell Phone: ()

Birth date: / / Sex: M F Age: Weight: Height:

Occupation: _____

Shoe Size: Activity/Sport (list all sports): _____

ASSESSMENT

R **NWB**
(circle one)

Varus / Neutral / Valgus

L
(circle one)

Varus / Neutral / Valgus

Rearfoot

Forefoot

Varus / Neutral / Valgus

Varus / Neutral / Valgus

1st Ray Position

N / ↑ / ↓

N / ↑ / ↓

(in relation to 2nd MTP)

1st Ray Mobility

F / SF / R

F / SF / R

1st MTP Joint Mobility

Normal / Limited / Rigidis

Normal / Limited / Rigidis

Knees

Varus / Neutral / Valgus

Varus / Neutral / Valgus

Leg Length Discrepancy

in / mm

in / mm

Please indicate short leg - R or L (circle one)

Please indicate - Structural / Functional (circle one)

Correct for:

(circle one)

Pronation / Supination

(circle one)

Pronation / Supination

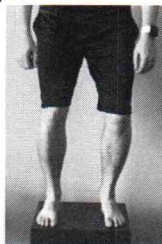
DIGITAL PICTURES REQUESTED:



1. Standing facing front



2. Standing facing back



3. Squatting facing front



4. Squatting facing back

SHOE RECOMMENDATION(S)

CUSTOM ORTHOTICS

- _____ All Purpose Full-Length
- _____ Soccer/Spike Full-Length
- _____ Dress Full-Length
- _____ Diabetic/Geriatric Full-Length
- _____ Sulcus Length
- _____ 3/4 Length
- _____ Ski/Skate Full-Length
- _____ Tennis Full-Length

SEMI-CUSTOM

- _____ Semi-Custom w/lab corrections

OVER-THE-COUNTER (OTC)

- _____ Stride Fit
- _____ Comfort Fit
- _____ Slim Fit

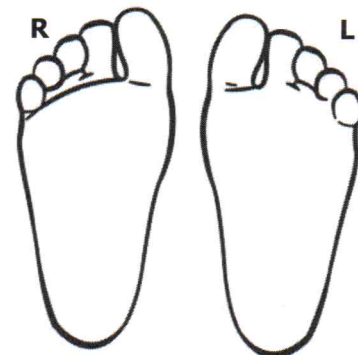
ACCOMODATIONS

- _____ Metatarsal Pad
- _____ Heel Pad
- _____ Deep Heel Cup
- _____ 1st Ray Morton's Extension
- _____ UCBL

TOP COVER

- _____ Standard
- _____ Diabetic/Geriatric

POSTING SPECIFICATIONS



Measurements

Standing (degrees of pronation) R FWB L
Squatting (degrees of pronation) R FWB L

Special Instructions:

LAB USE ONLY

Received: _____
Finished: _____
Fitting: ☐ Kentwood _____
☐ Muskegon _____
Send ☐

Physical Therapy Recommended ☐