

DEVICE No.: _____

ACCOUNT No.: _____

CUSTOMER NAME: _____ PATIENT NAME: _____

SHIP TO: _____ TELEPHONE: _____

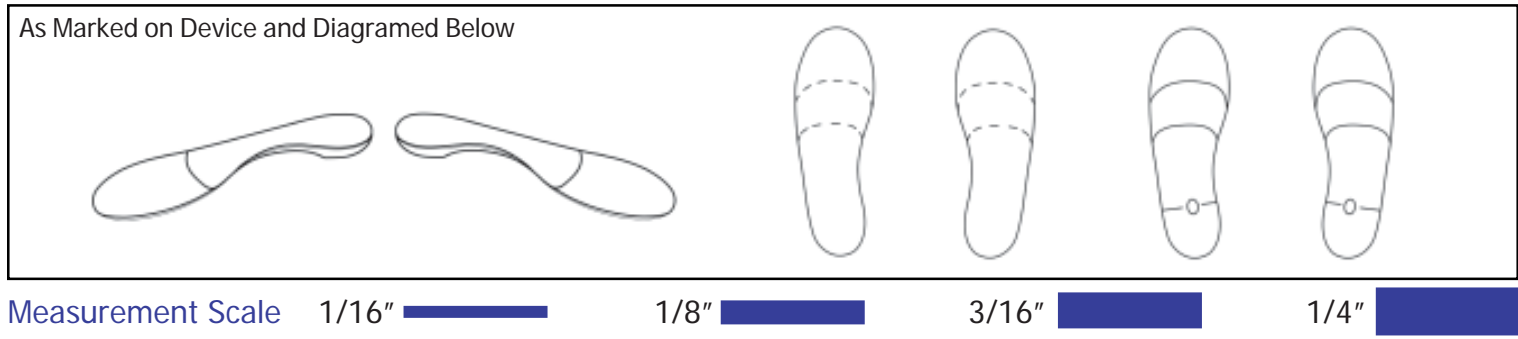
EXTENDED WARRANTY Y/N _____ SERVICE CONTRACT Y/N _____ DATE: _____





COVERING POSTING ADJUSTMENT FIT TO: SHOES INSOLE TEMPLATE

Patient Complains of: _____

Clinician Observes: _____

As Marked on Device and Diagrammed Below



Measurement Scale 1/16"  1/8"  3/16"  1/4" 

Covering
 __Recover (R)____ (L)____
 __Change Covers to: _____

 __Length: _____
 __Add Pads (R)____ (L)____
 __Remove Pads (R)____ (L)____
 __Move Pads (R)____ (L)____
 __Replace Pad with: _____

Posting
 __Apply New Post
 __Original Specs.
 __RF (R)____ (L)____
 __FF (R)____ (R)____
 __Angle Post @ Original Specs.
 __Angle Post as follows:
 __Angle RF (R)____ (L)____
 __Angle FF (R)____ (L)____
 __FF Post to Sulcus
 __FF Post to Mets
 __Heel Lift (R)____ (L)____

Adjustment
 Shell:
 __Narrow Device (R)____ (L)____
 __Taper Distal Edge (R)____ (L)____
 __Shorten
 Distal Edge (R)____ (L)____
 __Arch: Lower / Raise (R)____ (L)____

 __Reduce Heel Seat (R)____ (L)____

 __Arch Reinforcement:
 __Low-density EVA
 __Medium-density Crepe
 __Firm-density Crepe
 __Poron

Comments: _____

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