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DATE: _____

PRACTITIONER: _____ PATIENT NAME: * _____

CLINIC NAME: _____ PATIENT SHOE SIZE: * _____

ADDRESS: _____ PATIENT WEIGHT: * _____

EMAIL: _____ CHIEF COMPLAINT: _____

TELEPHONE: _____

PRESCRIPTION:

<p>ORTHOTIC SHELL</p> <p>2MM (UNDER 70KG) 3MM (OVER 70KG)</p> <p>LENGTH</p> <p>3/4 SULCUS FULL LENGTH</p>	<p>TOPCOVER</p> <p>NAUGAHYDE (SMOOTH LEATHER/VINYL) LUNAIRMED LUNASOFT — BLACK RED GREY/BLACK MARBLE WHITE/BLACK MARBLE ETC — BLUE BLACK STARSUEDE SUEDE LEATHER NEOPRENE</p>	<p>MET PADS</p> <p>YES ALL MET PADS 10MM DISTAL LO PROFILE AS STANDARD HIGH PROFILE 20MM DISTAL _____ MM</p>	<p>REARFOOT POST</p> <p>INTRIN. EXTRIN LEFT ° _____ RIGHT _____° VARUS VALGUS</p> <p>1ST MET CUTOUT</p> <p>LEFT RIGHT</p>
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FURTHER CUSTOMISATION:

<p>FOREFOOT PAD</p> <p>LEFT RIGHT</p>	<p>FULL HEEL CUSH.</p> <p>LEFT RIGHT</p>	<p>MORTONS EXT.</p> <p>LEFT RIGHT SOFT HARD</p>	<p>SCAPH PAD</p> <p>LEFT RIGHT NORMAL LOW</p>	<p>FOREFOOT POSTING EXTRIN.</p> <p>LEFT ° _____ RIGHT° _____ 3/4 SULCUS</p>												
<p>SUB MET ACCM.</p> <table border="0"> <tr><td>LEFT</td><td>RIGHT</td></tr> <tr><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td></tr> </table>	LEFT	RIGHT	1	1	2	2	3	3	4	4	5	5	<p>SPUR PAD</p> <p>LEFT RIGHT</p> <p>EXTRA PADDING (UNDER TOP COVER)</p> <p>1/16" 1/8"</p>	<p>REV MORTON</p> <p>LEFT RIGHT SOFT HARD</p>	<p>SHOCK ABSORBER (UNDER HEEL)</p> <p>LEFT RED RIGHT MARBLE</p> <p>1/16" 1/8"</p>	<p>HEEL RAISE</p> <p>LEFT _____ MM RIGHT _____ MM</p> <p>SOFT MEDIAL FLANGE</p> <p>LEFT RIGHT</p>
LEFT	RIGHT															
1	1															
2	2															
3	3															
4	4															
5	5															

ORTHOTIC TYPE:

<p>WOMEN <input type="checkbox"/></p> <p>MEN <input type="checkbox"/></p> <p>SPECIALISED <input type="checkbox"/></p>	<p>DRESSFLEX COURTFLEX</p> <p>SUPERFLEX RUNFLEX</p> <p>SOCCERFLEX CUSHIONFLEX</p>
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ADDITIONAL INFORMATION:

THE SPACE BELOW IS FOR OFFICE USE ONLY

DATE RECEIVED: _____	ORDER BY EMAIL: _____	<input type="checkbox"/> CONSULT	<input type="checkbox"/> INFO INCOMPLETE	LAB REPAIR COMPLETE: _____
LAB RECEIVED: _____	CAST/FOAM BOX: _____	<input type="checkbox"/> CALL	<input type="checkbox"/> EMAILED	DATE SHIPPED: _____