



Functional Foot Orthosis Prescription Form

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PAIENNT NAME _____ SEX _____ AGE _____ HEIGHT _____ WEIGHT _____

ADDRESS _____

HOSPITAL / CLINIC _____ ORTHOTIST / PODIATRIST _____

ADDRESS _____ TEL _____

ORTHOSIS TYPE (MATERIAL)	POSTING	POSTING ANGLES
CARBON FIBRE <input type="checkbox"/> SEMI RIGID <input type="checkbox"/> RIGID <input type="checkbox"/> X-RIGID COPOLYMER POYPROPYLENE <input type="checkbox"/> FLEXIBLE <input type="checkbox"/> SEMI-FLEXIBLE <input type="checkbox"/> RIGID EVA Soft Medium Firm	POST TO CAST <input type="checkbox"/> LAB EVALUATION <input type="checkbox"/> POST AS INDICATED <input type="checkbox"/> FOREFOOT POST <input type="checkbox"/> HINDFOOT POST <input type="checkbox"/> EXTRINSIC <input type="checkbox"/> INTRINSIC <input type="checkbox"/>	RIGHT HINDFOOT° VALGUS/VARUS FOREFOOT° VALGUS/VARUS KIRBY SKIVE° VALGUS/VARUS LEFT HINDFOOT° VALGUS/VARUS FOREFOOT° VALGUS/VARUS KIRBY SKIVE° VALGUS/VARUS
ACCOMMODATIONS/EXTENSIONS	COVERING MATERIALS	
HEEP CUP <input type="checkbox"/> SHALLOW <input type="checkbox"/> DEEP HEEL SPUR CUSHION <input type="checkbox"/> LEFT/RIGHT METATARSAL PAD <input type="checkbox"/> LEFT/RIGHT METATARSAL RAISE <input type="checkbox"/> LEFT/RIGHT VALGUS/NAVICULAR PAD <input type="checkbox"/> LEFT RIGHT HEEL RAISE <input type="checkbox"/> LEFT/RIGHT STATE HEIGHT cm		
COVERING MATERIALS	MICCL	
<input type="checkbox"/> Poron <input type="checkbox"/> Leather <input type="checkbox"/> Vinyl <input type="checkbox"/> PPT <input type="checkbox"/> EVA <input type="checkbox"/> Synthetic <input type="checkbox"/> 1.5 mm <input type="checkbox"/> 3 mm	SHOE TYPE & SIZE HEEL HEIGHT SPORTS ACTIVITIES OCCUPATION	
LENGTH <input type="checkbox"/> TO SULCUS <input type="checkbox"/> TO MET. HEAD <input type="checkbox"/> FULL LENGTH	ADDITIONAL INFORMATION	
Int. Order No. _____	Date Reqd. _____	Date Cast _____