PROLAB ORTHOTICS

CUSTOM ORTHOTIC PRESCRIPTION

TEL: (800) 477-6522
FAX: (866) 454-0763
www.prolaborthotics.com

Date: _____ PO#: _____ Account #: _____

Doctor: _____

Address: _____

City: _____ State / Zip: _____ Phone: _____

PATIENT NAME: _____ Med Rec #: _____

Dx: _____ Dr. Email: _____

For PROLAB office use only

SCAN

Asymmetric Feet? ☐ Yes ☐ No | ☐ Male ☐ Female | Age: _____ | Weight (**required**): _____ | Shoe Size: _____ | Shoe ☐ Enclosed

Select ONLY ONE device in Part A *(descriptions on back)* —OR— Complete Part B

A PATHOLOGY SPECIFIC ORTHOSES™

- ☐ Achilles Tendinitis
- ☐ Calcaneal Apophysitis
- ☐ Hallux Limitus/HAV
- ☐ Intoeing Gait (gait plate)
- ☐ Lateral Ankle Instability/Peroneal Tendinitis
- ☐ Metatarsalgia
- ☐ Neuroma
- ☐ Pediatric Flatfoot
- ☐ Pes Cavus with Rigid Forefoot
- ☐ Plantar Fasciitis due to Everted Rearfoot
- ☐ Plantar Fasciitis due to Forefoot Valgus
- ☐ Posterior Tibialis Dysfunction
  Navicular sweet spot (mark on cast) ☐ R ☐ L
- ☐ Sesamoiditis
- ☐ Sinus Tarsi Syndrome
- ☐ Tarsal Tunnel Syndrome

SPECIALTY ORTHOSES

- ☐ ProAerobic ☐ **Med** ☐ Firm
- ☐ Cobra
- ☐ Featherweight ☐ **Med** ☐ Firm
- ☐ Graphite Dress
- ☐ Graphite Functional
- ☐ Holethotic
- ☐ Plastazote Functional ☐ Med ☐ **Firm**
- ☐ UCBL

DIABETIC ACCOMMODATIVE*
(Foam Box Required)
Milled EVA Shell
☐ Med ☐ **Firm**
***Includes diabetic topcover (leather / P-cell / Poron)**

B POLYPROPYLENE SHELL

Choose ONE manufacturing method below

- ☐ Vacuum-Formed (VAC) — Black
- ☐ Vacuum-Formed (VAC) — White

—OR—

- ☐ Milled *(white only; includes poly post)*
- ☐ *No Post*

SHELL RIGIDITY

Choose Poly Thickness —OR— **Choose Shell Rigidity**

- ☐ 2mm *(milled only)*
- ☐ 3mm
- ☐ 4mm
- ☐ 5mm
- ☐ 6mm

*Patient Weight (required):*_____

- ☐ Flexible
- ☐ **Semirigid**
- ☐ Rigid

SIZE & CASTWORK *(defaults in bold)*

HEEL CUP DEPTH
- ☐ Shallow (10mm)
- ☐ **Standard (14mm)**
- ☐ Deep (18mm)
- ☐ _____ mm

WIDTH
- ☐ Narrow
- ☐ **Standard**
- ☐ Wide

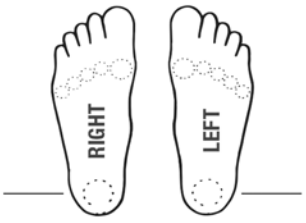
CAST FILL
- Minimum ☐ R ☐ L
- **Standard** ☐ R ☐ L
- Maximum ☐ R ☐ L

MEDIAL HEEL SKIVE
- 2mm ☐ R ☐ L
- 4mm ☐ R ☐ L
- 6mm ☐ R ☐ L

INVERT
- _____° R
- _____° L

SHELL ACCOMMODATIONS
- Medial Flange ☐ R ☐ L
- PF Groove ☐ R ☐ L
- Sweet Spot (w/ Poron) ☐ R ☐ L
- 1st Ray Cut-out ☐ R ☐ L

PLANTAR VIEW



Note WB heel width and mark all accommodations

REARFOOT POST

TYPE
- ☐ **Standard**
- ☐ Spot Grind
- ☐ Strip
- ☐ Hole

MOTION
- ☐ **0/0**
- ☐ 4/4

MATERIAL
- ☐ **EVA**
- ☐ Polypropylene

BEVEL
(Do not bevel post…)
- Medially ☐ R ☐ L
- Laterally ☐ R ☐ L

TOPCOVER OPTIONS

LENGTH
- ☐ **Toes**
- ☐ Sulcus
- ☐ Mets

GLUING
- ☐ **Glue All**
- ☐ Glue Posterior Half
- ☐ Glue Heel Only

MATERIAL
- ☐ 3mm Soft EVA (tricolor)
- ☐ **3mm Soft EVA (black)**
- ☐ 3mm Firm EVA (black)
- ☐ Diabetic (leather / P-cell / Poron)
- ☐ Leather (black)
- ☐ Nylene ☐ 1.5mm ☐ 3mm
- ☐ Sport
- ☐ Vinyl
- ☐ Add Poron under topcover ☐ 1.5mm ☐ 3mm
- ☐ Bottom Cover (vinyl)

FOREFOOT EXTENSIONS

LENGTH ☐ R ☐ L
- ☐ Toes
- ☐ **Sulcus**
- ☐ Beveled on Device

MATERIAL
- ☐ **Poron**
- ☐ Korex
- ☐ EVA ☐ **Soft** ☐ Firm

THICKNESS
- ☐ 1.5mm ☐ **3mm** ☐ 5mm ☐ 6mm

ADD — **Unweight met heads #:**
- ☐ **Slot** *(mark on diagram)* _____ R _____ L
- ☐ Punch *(mark on diagram)*
- ☐ Valgus Extension _____° R _____° L
- ☐ Varus Extension _____° R _____° L
- ☐ Rev. Morton's Extension ☐ R ☐ L
- ☐ Morton's Extension ☐ R ☐ L

SPECIAL ADDITIONS

- Arch Pad ☐ R ☐ L
- EVA Arch Fill ☐ R ☐ L
  ☐ *Medium*
  ☐ *Firm*
- Heel Lift _____mm R _____mm L
  ☐ *Taper lift to mets (requires EVA fill)*
- Heel Pad ☐ R ☐ L
- Horseshoe Pad ☐ R ☐ L
- Metatarsal Pad ☐ R ☐ L
- Metatarsal Bar ☐ R ☐ L
- Neuroma Pad ☐ R ☐ L
  ☐ _____ *Interspace*
- Toe Filler *(must send shoes)* ☐ R ☐ L

SPECIAL INSTRUCTIONS — *Extra charges may apply*

- ☐ Adjust *(within 90 days of original order)*
- ☐ Refurbish as before ☐ Refurbish as prescribed above

_____

_____

_____

Doctor's Signature *(required)* _____

ORDER PROCESSING *(Rush items ship overnight)*
- ☐ RUSH — 1 day in lab
- ☐ RUSH — 3 day in lab

SPECIAL SHIPPING
- ☐ FedEx Overnight
- ☐ FedEx Ground
- ☐ Ship to Patient

REORDERS

(Fax reorders to 707-257-4420)
- ☐ Exactly as before
- ☐ As prescribed above

Image # _____
(Reference number from bottom of orthotics)