

PATIENT			
Last Name:			
First Name:			
DOB:		Bilateral	Left Right

BILLING		RUSH ORDER(\$)	
Name:			
Address:			
City:	State:	Zip:	
PO#:			

PRACTITIONER	
Name:	Title:
Email:	
Phone:	

SHIPPING		Same as Billing	
Name:			
Facility:			
Address:			
City:	State:	Zip:	

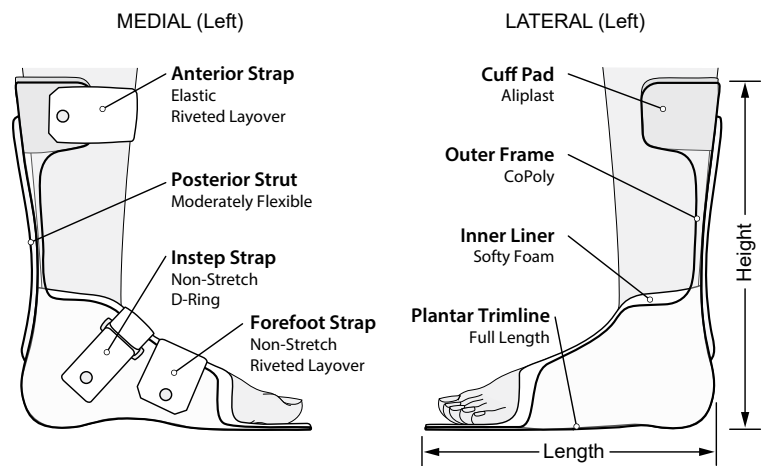
NOTE: If no options are selected, you will receive the **DAFO Standard** (see illustration).

POSITION OF FUNCTION			
BRACE HEIGHT:			
Standard	Specify:	_____ mm	
BRACE LENGTH:			
Standard	Specify:	_____ mm	
ANKLE ALIGNMENT:			
3° DF	_____° DF	_____° PF	Do Not Correct
HINDFOOT ALIGNMENT:			
Vertical	Correct Halfway	Do Not Correct	
FOREFOOT ALIGNMENT:			
Neutral	Varus: _____ mm	Valgus: _____ mm	
Do Not Correct			

STABILITY				
STABILIZATION:				
None	Heel	Midfoot	Heel-to-Midfoot	Heel-to-Toe
NON-SKID:				
None	Vibram			

CONTROL			
INNER LINER:			
Softy Foam	Polyethylene	OP Flex (\$)	
POSTERIOR STRUT:			
Moderately Flexible	Semi-Rigid		
Very Flexible	Very Rigid		
PLANTAR (OUTER TRIMLINE):			
Full Length	Distal to Met. Head	Proximal to Met. Head	
STANDARD FOR SOFTY FOAM LINER	STANDARD FOR POLYETHYLENE LINER		

LATERAL MET. HEAD (OUTER TRIMLINE):			
At Met. Head	Distal	Proximal	Long Containment
MEDIAL MET. HEAD (OUTER TRIMLINE):			
At Met. Head	Distal	Proximal	Long Containment
SOFT CONTAINMENT:			
None	Lateral	Medial	Lateral & Medial
TOE RISE:			
Toe Rise	Toe Rise w/ Abduction Strap		



COMFORT	
TALUS & NAVICULAR PADDING:	
None	Add PPT
COSMETIC	
ALIPLAST PAD COLOR:	
White	Specify: _____
STRAP COLOR:	
White	Specify: _____
TRANSFER:	
None	Specify: _____

ADDITIONAL INSTRUCTIONS	