

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

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

PRACTITIONER	
Name:	Title:
Email:	
Phone:	

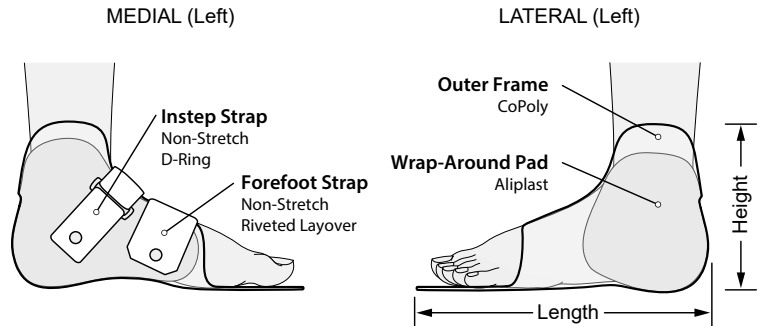
SHIPPING		Same as Billing	
Name:			
Facility:			
Address:			
City:	State:	Zip:	

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:
Do Not Correct			

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

CONTROL			
PROXIMAL STRAP:			
Anterior	Posterior	Anterior & Posterior	
PROXIMAL STRAP MATERIAL:			
Non-Stretch	Elastic		
LATERAL MET. HEAD (TRIMLINE):			
At Met. Head	Distal	Proximal	Long Containment
MEDIAL MET. HEAD (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	