

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 LENGTH:

Standard Specify: _____ mm

HINDFOOT ALIGNMENT:

Vertical Correct Halfway Do Not Correct

FOREFOOT ALIGNMENT:

Neutral Varus: _____ mm Valgus: _____ mm
Do Not Correct

STABILITY

STABILIZATION:

Medial Heel-to-Midfoot Heel Midfoot
Heel-to-Toe None

NON-SKID:

None Vibram

CONTROL

INNER LINER:

Softy Foam Polyethylene OP Flex (\$)

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):

Distal Proximal At Met. Head Long Containment

MEDIAL MET. HEAD (OUTER TRIMLINE):

Proximal Distal At Met. Head Long Containment

SOFT CONTAINMENT:

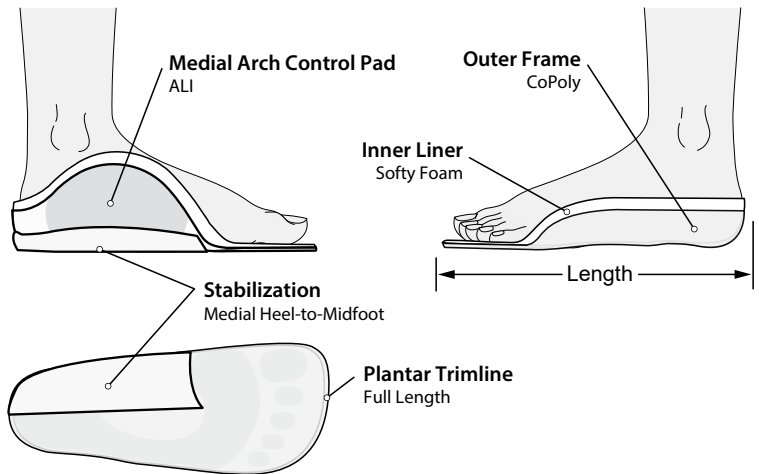
None Lateral Medial Lateral & Medial

TOE RISE:

Toe Rise Toe Rise w/ Abduction Strap

MEDIAL (Left)

LATERAL (Left)



COMFORT

TALUS & NAVICULAR PADDING:

None Add PPT

COSMETIC

ALIPLAST PAD COLOR:

White Specify: _____

TRANSFER:

None Specify: _____

ADDITIONAL INSTRUCTIONS