

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 OP Flex (\$)

LATERAL MET. HEAD (OUTER TRIMLINE):

At Met. Head Distal Proximal Long Containment

MEDIAL MET. HEAD (OUTER TRIMLINE):

At Met. Head Distal Proximal Long Containment

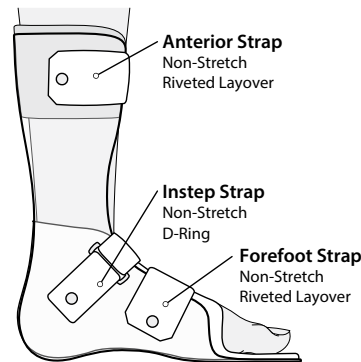
SOFT CONTAINMENT:

None Lateral Medial Lateral & Medial

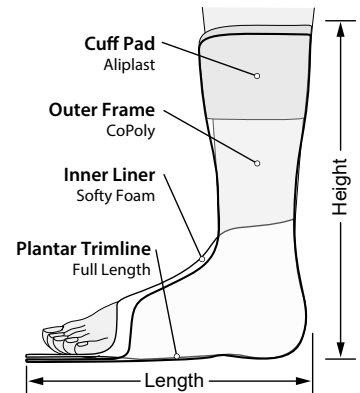
TOE RISE:

Toe Rise Toe Rise w/ Abduction Strap

MEDIAL (Left)



LATERAL (Left)



COMFORT

TALUS & NAVICULAR PADDING:

None Add PPT

COSMETIC

ALIPLAST PAD COLOR:

White Specify: _____

STRAP COLOR:

White Specify: _____

TRANSFER:

None Specify: _____

ADDITIONAL INSTRUCTIONS