STRIDE™

CUSTOM ORTHOTICS

ORDER FORM

ACCOUNT INFORMATION

Office: _____

Practitioner's Name: _____

Phone: _____ P.O.#: _____

Shipping Address: _____

_____

Billing Address: _____

_____

PATIENT INFORMATION

Name: ☐☐☐☐☐☐☐☐☐☐☐☐ first

☐☐☐☐☐☐☐☐☐☐☐☐ last

Diagnosis: _____

Age: _____ Height: _____ Weight: _____ Sex: _____

Shoe Size:_____ Shoe Style: ☐ Athletic ☐ Dress (____" heel height)
(please choose only one shoe style per order)

Sports: _____

Occupation: _____

Activity Level: ☐ Low ☐ Medium ☐ High

STRIDE FOOT ORTHOTICS: STANDARD LENGTH OR FULL LENGTH TOP COVERS

	VINYL TOP COVER	FULL LENGTH TOPCOVER OPTIONS
☐ BASIC FOOT ORTHOTIC	☐ TO MTH	☐ Vinyl ☐ Neolon ☐ JFoam ☐ Plast ☐ Poron
☐ EXTENDED BASIC FOOT ORTHOTIC	☐ TO SULCUS	☐ Vinyl ☐ Neolon ☐ JFoam ☐ Plast ☐ Poron
☐ COPOLY FOOT ORTHOTIC	☐ TO MTH	☐ Vinyl ☐ Neolon ☐ JFoam ☐ Plast ☐ Poron
☐ EXTENDED COPOLY FOOT ORTHOTIC	☐ TO SULCUS	☐ Vinyl ☐ Neolon ☐ JFoam ☐ Plast ☐ Poron
☐ STANDARD DRESS ORTHOTIC	☐ TO MTH	☐ FULL LENGTH VINYL (Only Option)
☐ SLIM DRESS ORTHOTIC (FOR HEELED SHOES)	☐ TO SULCUS WITH MTM	☐ FULL LENGTH VINYL (Only Option)
☐ 2ND PAIR DRESS ORTHOTIC	☐ DATE OF FIRST ORDER (/ /)	Original Order No: _____
☐ DEPTH ORTHOTIC	☐ TO MTH (Plast Cover)	☐ JFoam ☐ Plast (Only Two Options)
☐ EXTENDED DEPTH ORTHOTIC	☐ TO SULCUS (Plast Cover)	☐ JFoam ☐ Plast (Only Two Options)
☐ DIABETIC FOOT ORTHOTIC	☐ N/A	☐ Full Plastizote Cover (Only Option)
☐ ARTHRITIC FOOT ORTHOTIC	☐ N/A	☐ Vinyl ☐ Neolon ☐ JFoam ☐ Plast ☐ Poron

Please refer to price list for description of orthotic models

INLAYS OR ADDITIONS (LEFT, RIGHT OR BILATERAL)

☐ METATARSAL BAR (Padding)	L R B	☐ MEDIAL LONGITUDINAL ARCH PADDING	L R B
☐ MET BAR with MTH CUTOUT	L R B (12345)	☐ CUBOID PAD	L R B
☐ METATARSAL MOUND	L R B	☐ FOREFOOT VALGUS INLAY	L R B
☐ ARCH FILLER (Beneath Shell)	L R B	☐ MEDIAL SKIVE	L R B
☐ HEEL CUSHION	L R B	☐ MORTON'S EXTENSION	L R B

☐ HEEL LIFT: _____(height) L R B (Please indicate: ☐ ATTACHED OR ☐ UNATTACHED TO HEEL POST)

POSTING INSTRUCTIONS

☐ PLEASE CALL FOR CONSULTATION UPON RECEIVING CASTS (Phone:_____ Best time to call: _____)

☐ POST TO LAB'S DISCRETION **(OR)** ☐ POST AS SPECIFIED

REARFOOT POSTING:

☐ VARUS POSTING

_____° L _____° R

FOREFOOT POSTING: ☐ **Intrinsic** ☐ **Extrinsic** ☐ **Combined**

(Please indicate the degree of Extrinsic Posting Desired)

_____° L ☐ VARUS ☐ VALGUS

_____° R ☐ VARUS ☐ VALGUS

RUSH ORDERS

☐ 72HR RUSH (3 WORKING DAYS) $35.00 CHARGE ☐ 1 WEEK RUSH (5 WORKING DAYS) $25.00

PLEASE SEND: ☐ MALING BOXES ☐ MAILING LABELS ☐ EVALUATION FORMS ☐ ORDER FORMS

7 KNIGHT STREET, WATERTOWN, CT. 06795
PHONE: (860) 274-4273 or (800) 787-7879 FAX: (203) 598-0075