

FIRST CHOICE ORTHOTIC RX

Account # _____ P.O. #: _____
Account Name _____
Practitioner Name _____
Phone _____ Fax _____
Email _____
Street Address _____
City/St/Zip/Postal Code _____
☐ Recast from previous order
Serial # _____
☐ 5-Day Rush - (\$25 Fee)

Serial # _____
Opened By _____ Incoming Postage _____
Date Received _____

Patient's Name _____
Street Address _____
City/St/Zip/Postal Code _____
Telephone () _____
Sex ☐ M ☐ F Age _____ Height _____ Weight _____
Shoe Size _____
LACED ☐ Low volume interior ☐ High volume interior
☐ Athletic ☐ Safety boots ☐ Other _____

Protect® Program Serial # _____ ☐ Repair ☐ Outgrow ☐ Loss **Attach copy of patient's Protect Agreement**

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ORTHOTICS

Choose one device with standard topcover

- ☐ FirstChoice Accommodative (1/16" Black Starsuede Topcover to Sulcus)
☐ FirstChoice Sport (1/8" Blue ETC Topcover to metatarsals)
☐ FirstChoice Composite (1/8" Blue ETC to metatarsals)
☐ FirstChoice Dress (Black Vinyl to sulcus)
☐ FirstChoice Semi-Flex (1/16" Black Starsuede to toes)
☐ FirstChoice Pediatric (1/16" Black Starsuede to metatarsals)

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SPECIAL COVERING REQUESTS (OPTIONAL)

Choose one alternate topcover to replace standard topcover

- | | | | |
|---------------------------------------|--------------------------|----------------------|--------------------------|
| 1/8" Blue ETC | <input type="checkbox"/> | 3/16" Plastazote | <input type="checkbox"/> |
| 3/16" Blue ETC (extra padding) | <input type="checkbox"/> | 1/8" Multicolor EVA | <input type="checkbox"/> |
| 1/16" Black Starsuede | <input type="checkbox"/> | 1/16" Multicolor EVA | <input type="checkbox"/> |
| 3/16" Black Starsuede (extra padding) | <input type="checkbox"/> | 1/8" Neoprene | <input type="checkbox"/> |
| Black Vinyl (no padding) | <input type="checkbox"/> | 1/16" Neoprene | <input type="checkbox"/> |
- ☐ To Metatarsal ☐ To Sulcus ☐ To Toes

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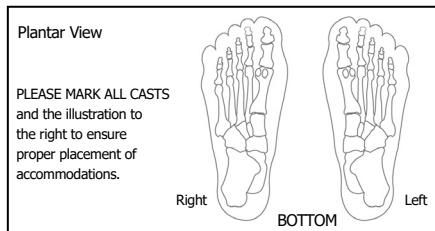
ADDITIONS AND MODIFICATIONS

	Right	Left
Heel Spur Balance	<input type="checkbox"/>	<input type="checkbox"/>
Heel Cushion	<input type="checkbox"/>	<input type="checkbox"/>
Heel lift 1/8"	<input type="checkbox"/>	<input type="checkbox"/>
Heel lift 3/16"	<input type="checkbox"/>	<input type="checkbox"/>
Heel lift 1/4"	<input type="checkbox"/>	<input type="checkbox"/>
1st Ray Cut Out	<input type="checkbox"/>	<input type="checkbox"/>
Hole in Heel <input type="checkbox"/> include Foam Disk	<input type="checkbox"/>	<input type="checkbox"/>
Medial Flange	<input type="checkbox"/>	<input type="checkbox"/>
Lateral Flange	<input type="checkbox"/>	<input type="checkbox"/>
Morton's Extension	<input type="checkbox"/>	<input type="checkbox"/>
Reverse Morton's Extension	<input type="checkbox"/>	<input type="checkbox"/>
Neuroma Pad	<input type="checkbox"/>	<input type="checkbox"/>
3rd interspace unless specified _____		
Neuroma Plug	<input type="checkbox"/>	<input type="checkbox"/>
Interspace _____		
Metatarsal Pad	<input type="checkbox"/>	<input type="checkbox"/>
Metatarsal Bar	<input type="checkbox"/>	<input type="checkbox"/>
Scaphoid Pad	<input type="checkbox"/>	<input type="checkbox"/>
Balance Pad Right (please circle)	1 2 3 4 5	
Balance Pad Left (please circle)		1 2 3 4 5
Deep Heel Seat	<input type="checkbox"/>	<input type="checkbox"/>
Gait Plate to promote (Pediatric Only)	<input type="checkbox"/> in toe	<input type="checkbox"/> out toe

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POSTING VALUES

	Right	Left
Forefoot		
Intrinsic	____ Varus	____ Varus
	____ Valgus	____ Valgus
Forefoot		
Extrinsic	____ Varus	____ Varus
	____ Valgus	____ Valgus
Rearfoot		
Intrinsic	____ Varus	____ Varus
Extrinsic	____ Varus	____ Varus



DIAGNOSIS/CHIEF COMPLAINT/SPECIAL INSTRUCTIONS

