

Account Name _____	Phone (____)____-____
Address _____	Date ____-____-____
City _____	State ____ Zip ____
Practitioner Name _____	e-mail _____

Patient Name	<input type="text"/>	M □ / F □
Patient Weight	<input type="text"/> lbs	Diagnosis _____
Principal Reason for the AFO _____		
Is Patient currently <input type="radio"/> Ambulatory <b>OR</b> <input type="radio"/> Non-Ambulatory? Activity Level _____		

## TRADITIONAL AFO Rx FORM

**CAST MODS**

Rigid foot: Leave As Is

Flexible: Correct to Neutral

Correct Ankle Varus/Valgus

Correct Forefoot to Neutral

**STYLE**

Solid Ankle       PLS

Semi-Solid       SMO

Articulating Ankle

**Ankle Joints:**

Free Motion       Dorsi-Assist

Tamarack       Gillette

Oklahoma       Camber Axis

Gaffney       Other \_\_\_\_\_

**Stop:**  90°       Adjustable

**Straps:**  Instep       Ankle

**MATERIAL**

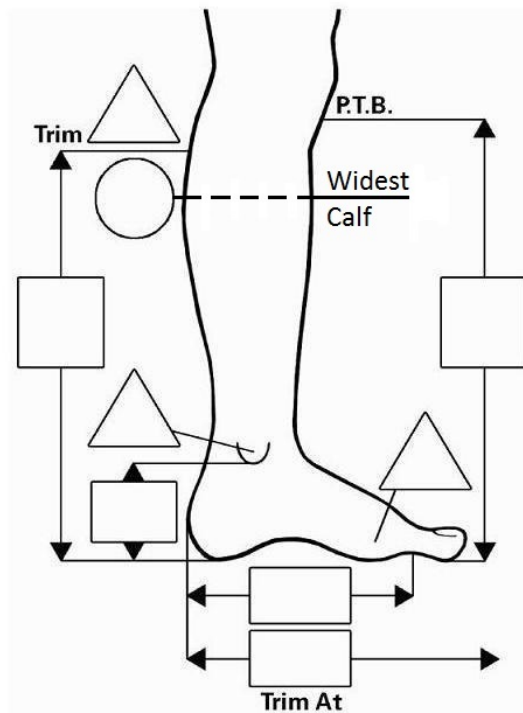
Polypro       Copoly

**Lining:**

Volara       Plastazote

**FOOTPLATE LENGTH**

Mets       Sulcus       Full



## SPECIAL INSTRUCTIONS