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Prosthesis RX

Account: _____ Date: ____/____/____
 Address: _____
 City: _____ State: _____ Zip: _____
 Practitioner Name: _____
 Phone: (____) _____ P.O. Number: _____
 E-mail: _____

Patient Name: _____
BK OR AK? **Left OR Right?** **Height:** _____
Weight: _____ **Shoe Size:** _____ M | F
 Activity Level: _____

Initial Fit

- Check Socket
- Material
 - PETG (Seamed) Orfitrans Stiff (No Seam)

Final Fab

- Changes to mold from check socket

- Outer Material [Standard OR [Heavy Duty
 - Co-Poly Carbon Acrylic Laminate
- Cut Outs on frame: _____
- Inner Socket
 - Proflex (Flexible) Orfitrans X-Soft (Semi-Rigid) Polyethylene (Rigid - BK only)

Additions

- Distal end pad
- Other: _____

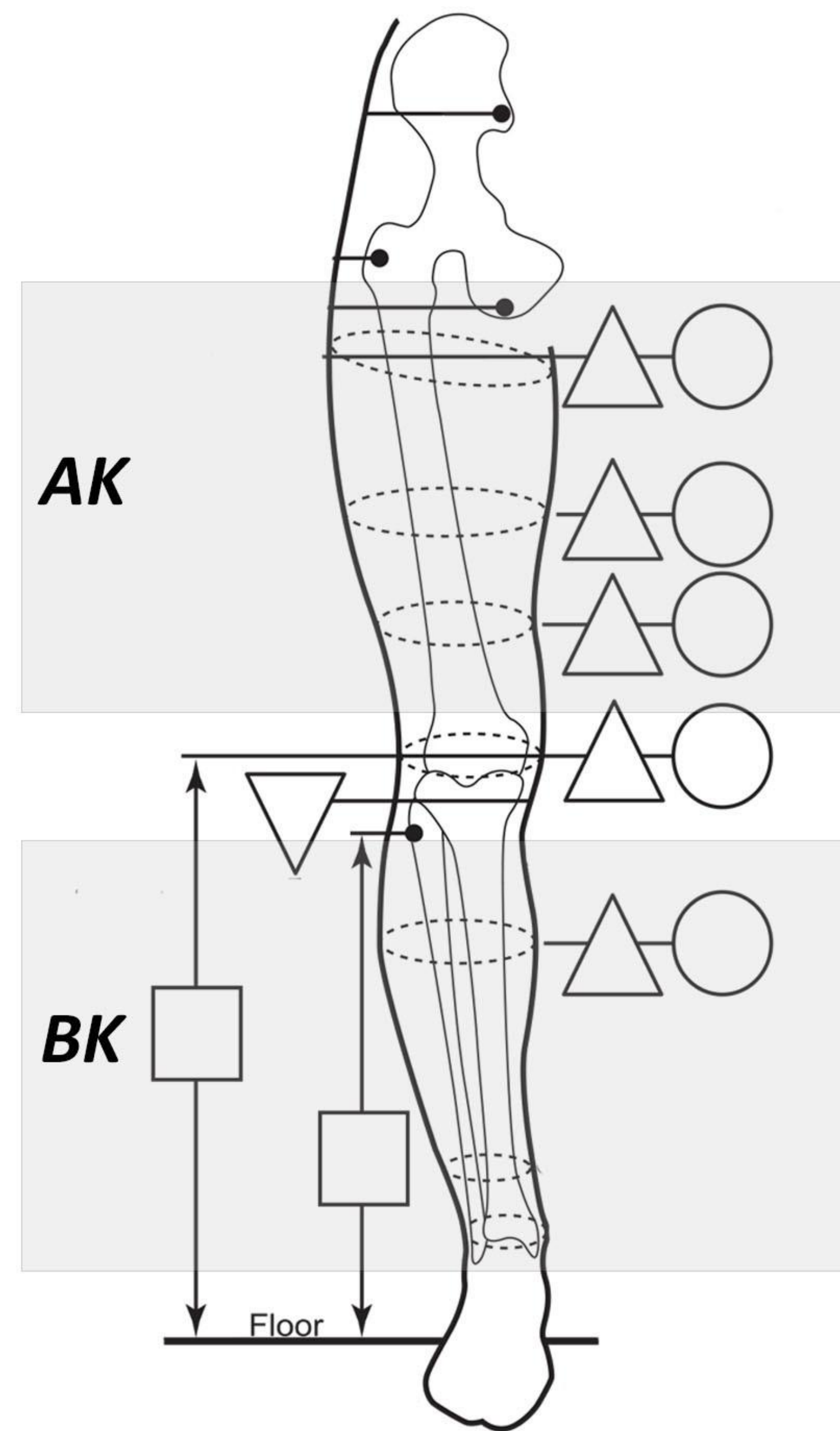
Cosmetics

- Cover: _____
- Custom Transfer _____

- Color: [Snow White
 [Caucasian [Caucasian Light [Latin
 [Light Negroid [Dark Negroid [Oriental
- or PRS Color Swatch Number _____

Components

- Lock Type? _____
- Valve Type? _____
- Alignment Device
Type? _____
- Attachment Device
Type? _____
- External Suspension
Type? _____
- Other _____



* Please cast over liner OR Provide liner with cast
 * Mark line of progression on distal end of cast

Special Instructions:

