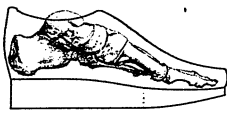
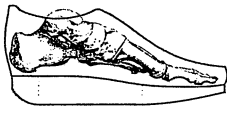
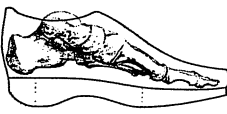
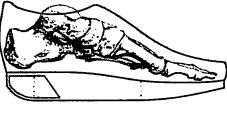
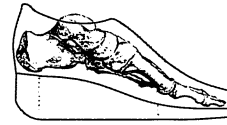
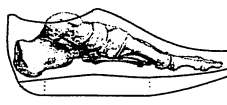
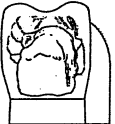




SHOE MODIFICATION

Patient _____ PO# _____ Diagnosis _____
 Clinic _____ Due Date (Rush Fee May Apply) _____
 Clinician _____ Height _____ Weight _____
 Phone _____ Age _____ Sex _____ Shoe Size _____

PATIENT ID	<small>INTERNAL USE - DO NOT FILL IN PATIENT ID</small>
-------------------	---

Step 1: Modification Type

L B R TOE ROCKER	L B R HEEL & TOE ROCKER	L B R DOUBLE ROCKER
		
L B R SACH	L B R POSITIVE HEEL LIFT	L B R NEGATIVE HEEL LIFT
		
L B R BOLSTER	L B R WEDGE	L B R FLARE
<input type="checkbox"/> Medial Bolster <input type="checkbox"/> Lateral Bolster 	<input type="checkbox"/> Medial Wedge <input type="checkbox"/> Lateral Wedge 	<input type="checkbox"/> Medial Flare <input type="checkbox"/> Lateral Flare 

Modification material will be selected based on patient weight.

Step 2: Measurements

LEFT REARFOOT	LEFT FOREFOOT	RIGHT REARFOOT	RIGHT FOREFOOT
<input type="checkbox"/> Change Height By Medial Lateral Both ± _____ ± _____ ± _____	<input type="checkbox"/> Change Height By Medial Lateral Both ± _____ ± _____ ± _____	<input type="checkbox"/> Change Height By Medial Lateral Both ± _____ ± _____ ± _____	<input type="checkbox"/> Change Height By Medial Lateral Both ± _____ ± _____ ± _____
<input type="checkbox"/> Total Height Welt to Floor Medial Lateral Both _____	<input type="checkbox"/> Total Height Welt to Floor Medial Lateral Both _____	<input type="checkbox"/> Total Height Welt to Floor Medial Lateral Both _____	<input type="checkbox"/> Total Height Welt to Floor Medial Lateral Both _____

It is not necessary to fill in original measurements or measurements that will not be changed.

(P) 210-657-8100
 (F) 210-657-8105

RECEIVED DATE	COMPLETED DATE

info@aodcfab.com