

1 PRACTICE INFORMATION

Practice: _____
 Address: _____
 Practitioner: _____
 Telephone: _____ Contact me to review Order Form

EVERFEET ORTHOTICS
 319 Julian Avenue
 Thomasville NC 27360
 Tel: (336) 472-0000
 Fax: (336) 472-0021
 info@everfeetlabs.com
 www.everfeetlabs.com

PREMIUM ORTHOTICS ORDER FORM

Date: _____

2 PATIENT INFORMATION

First Name: _____
 Last Name: _____
 Med. Rec.#: _____
 DOB: _____ Sex: M F Weight: _____ lbs Shoe Size: _____
 Chief Complaint: _____

Ship to Patient

Street Address: _____
 City: _____ State: _____ Zip: _____

3 ORDER INFORMATION







Pair(s) _____ Right(s) _____ Left(s) _____ Duplicate INV#: _____ **FIT ORTHOTICS TO:** Tracing Insoles Shoes
PRODUCTION: 10 Day Service 5 Day Service \$25 3 Day Service \$50 2 Day Service \$75 1 Day Service \$200

4 ORTHOTICS






SELECT ONE PER ORDER FORM

FUNCTIONAL	DRESS	ACCOMMODATIVE	By PATHOLOGY		
<input type="checkbox"/> Sport Classic	<input type="checkbox"/> Cosmo	<input type="checkbox"/> EVA ^{A5514}	<input type="checkbox"/> Achilles Tendinitis	<input type="checkbox"/> Metatarsalgia	<input type="checkbox"/> Pes Planus
<input type="checkbox"/> Healthfeet	<input type="checkbox"/> Sling _{Fashion}	<input type="checkbox"/> Korex	<input type="checkbox"/> Hallux Limitus	<input type="checkbox"/> Neuroma	<input type="checkbox"/> Plantar Fasciitis
<input type="checkbox"/> Marathon	<input type="checkbox"/> Cobra _{High Heels}	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Heel Spur	<input type="checkbox"/> Pediatric Flatfoot	<input type="checkbox"/> PTTD
<input type="checkbox"/> U.C.B.L.		<input type="checkbox"/> 3 Pairs Diabetic	<input type="checkbox"/> Intoeing Gait	<input type="checkbox"/> Peroneal Dysfunction	<input type="checkbox"/> Sesamoiditis
<input type="checkbox"/> Sport Specific: _____			<input type="checkbox"/> Lateral Ankle Instability	<input type="checkbox"/> Pes Cavus	Other _____

5 ORDER INFORMATION

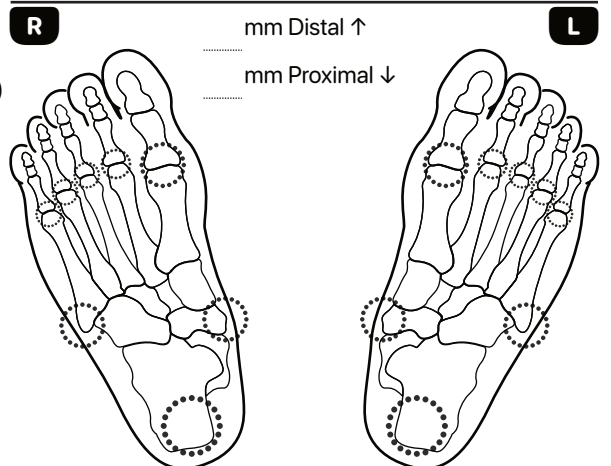
SHELL RIGIDITY	SHELL WIDTH	TOP COVER	LENGTH	EXTRA CUSHION	BOTTOM COVER
<input type="checkbox"/> Flexible	<input type="checkbox"/> Narrow	<input type="checkbox"/> 1 mm Vinyl	<input type="checkbox"/> Mets 	<input type="checkbox"/> 1.5 <input type="checkbox"/> 3 mm PPT	<input type="checkbox"/> EVA
<input type="checkbox"/> Semi Rigid	<input type="checkbox"/> Standard	<input type="checkbox"/> 3 mm EVA	<input type="checkbox"/> Sulcus 	<input type="checkbox"/> Heel 	<input type="checkbox"/> Suede
<input type="checkbox"/> Rigid	<input type="checkbox"/> Wide	<input type="checkbox"/> 3 mm Plastazote	<input type="checkbox"/> Toes 	<input type="checkbox"/> Forefoot 	<input type="checkbox"/> Suede Wrap
<input type="checkbox"/> Graphite		<input type="checkbox"/> 3 mm Spenco		<input type="checkbox"/> Full Device 	
		<input type="checkbox"/> 1 mm Glove Leather			

6 CORRECTIONS, MODIFICATIONS & PADS

HEEL CUP	REARFOOT POST		ARCH FILLER	FOREFOOT POST
<input type="checkbox"/> Shallow	<input type="checkbox"/> Intrinsic	R _____ L mm Heel Lift 	<input type="checkbox"/> Plastazote	<input type="checkbox"/> Intrinsic 
<input type="checkbox"/> Medium	<input type="checkbox"/> Extrinsic	°R _____ °L Medial Heel Skive 	<input type="checkbox"/> EVA	<input type="checkbox"/> Extrinsic 
<input type="checkbox"/> Deep	°R _____ °L Varus	°R _____ °L Lateral Heel Skive 	<input type="checkbox"/> Korex ^{275 lbs+}	°R _____ °L Varus
	°R _____ °L Valgus			°R _____ °L Valgus

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> R <input type="checkbox"/> L  Heel Punch | <input type="checkbox"/> R <input type="checkbox"/> L  1 st Ray Cut Out |
| <input type="checkbox"/> R <input type="checkbox"/> L  Heel Spur Pad | <input type="checkbox"/> R <input type="checkbox"/> L  5 th Ray Cut Out |
| <input type="checkbox"/> R <input type="checkbox"/> L  Navicular Relief | <input type="checkbox"/> R <input type="checkbox"/> L  Morton's Ext. (EVA) |
| <input type="checkbox"/> R <input type="checkbox"/> L  5 th Met Base Relief | <input type="checkbox"/> R <input type="checkbox"/> L  Morton's Ext. (Rigid) |
| <input type="checkbox"/> R <input type="checkbox"/> L  Fascia Groove Relief | <input type="checkbox"/> R <input type="checkbox"/> L  Rev. Morton's Ext. |
| <input type="checkbox"/> R <input type="checkbox"/> L  Cuboid Pad | <input type="checkbox"/> R <input type="checkbox"/> L  Metatarsal Pad 2-4 |
| <input type="checkbox"/> R <input type="checkbox"/> L  Lateral Flange | <input type="checkbox"/> R <input type="checkbox"/> L  Metatarsal Bar 1-5 |
| <input type="checkbox"/> R <input type="checkbox"/> L  Medial Flange | <input type="checkbox"/> R <input type="checkbox"/> L  Dancer's Pad |
| <input type="checkbox"/> R <input type="checkbox"/> L  Medial Flap | <input type="checkbox"/> R <input type="checkbox"/> L  Neuroma Pad |
| <input type="checkbox"/> R <input type="checkbox"/> L  Scaphoid Pad | <input type="checkbox"/> R <input type="checkbox"/> L  Toe Crest Pad |

7 PLANTAR ASPECT



! Please use image or impression to mark the place of the Balance, Pads, Toe Filler or Relief required.

!! Lab standards will apply when order form is incomplete.

!!! If shoe size is not supplied, any repair charges will be applied.

Special Instructions: _____