

Please:

- Submit one form for each pair ordered.
- Call ahead with any special instructions.
- Avoid processing delays by providing ALL requested information.
- **Order carefully.** Additions and accommodations requested after the initial order is placed will incur a fee.

LAB USE ONLY

Serial # _____

Opened By _____ Incoming Postage _____

Date Received _____

Account # _____ P.O. #: _____

Account Name _____

Practitioner Name _____

Phone _____ Fax _____

Email _____

Street Address _____

City/St/Prov _____

Zip/Postal Code _____

Recast from previous order Return cast to clinician

Serial # _____

Custom copy authorization

Patient's First Name _____ Last Name _____

Street Address _____

City/St/Zip/Postal Code _____

Telephone () _____

Diagnosis or Chief Complaint _____

Date of Birth (M/D/Y) _____

Sex M F Height _____ Weight _____

Shoe Size _____ Shoes Enclosed

PUMP Flat Low heel High heel

LACED Low volume interior High volume interior Athletic

Safety boots Other _____

Protect® Program Serial # _____ Repair Outgrow Loss (surcharge enclosed) Bill account for surcharge

This is a prepaid order

Check enclosed Check# _____

Money order enclosed Check# _____

Charge to: MasterCard VISA AmEx Discover

Expiration Date _____ Signature _____

SPOROTHOTICS®

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ALLSPORT (To metatarsals) | <input type="checkbox"/> CYCLIST (To sulcus) | <input type="checkbox"/> ATP TENNIS (To toes) | <input type="checkbox"/> SKI/SKATE (To toes) |
| <input type="checkbox"/> ALLSPORT CLASSIC (To metatarsals) | <input type="checkbox"/> MARATHONER (To sulcus) | <input type="checkbox"/> BASKETBALL (To toes) | <input type="checkbox"/> SPRINTER (To toes) |
| <input type="checkbox"/> ALLSPORT FLEXIBLE (To metatarsals) | <input type="checkbox"/> RUNNER'S MOULD (To sulcus) | <input type="checkbox"/> GOLF (To toes) | <input type="checkbox"/> TENNIS/RACQUETBALL (To toes) |
| <input type="checkbox"/> FOOTBALL (To metatarsals) | <input type="checkbox"/> SOCCER (To sulcus) | <input type="checkbox"/> HEALTHFLEX® (To toes) | |

FASHION DEVICES

- SLIMTHOTICS®** (To sulcus)
- Extension width 1st to 3rd metatarsal heads
- Extension width 1st to 5th metatarsal heads
- Full width forefoot shell 1st to 5th metatarsal heads with 1/16" PPT® extension
- DESIGNLINE®** (To sulcus)
- DRESSFLEX®** (To sulcus)
- ULTRA SLIMS** (To sulcus)
- SUPERFORM STYLATIC®** (To sulcus)

CONTROLLING/FUNCTIONAL DEVICES

- D.S.I.S. [Dynamic Stabilizing Insole System]** (To metatarsals)
- GAITFLEX** (To toes)
- LYTE FIT®** (To metatarsals)
- RIGIDUR** (To metatarsals)
- HEEL FIT® Firm** (To toes)
- HEEL FIT® Flexible** (To toes)
- U.C.B.L.** (To metatarsals)

THERACARE DEVICES

- SOFT** (To toes) **SPR** (To toes) **FIRM** (To toes)

ACCOMMODATIVE DEVICES

- BLUELINE** (To sulcus)
- Available fillers PPT®(soft) EVA (medium) Thermocork (firm)
- LEATHER MOULDS** (To sulcus)
- PPT® EVA Thermocork Laminate

Please Indicate modifications on reverse side of form

Account # _____ Account Name _____

- Please send me the following FREE supplies/information**
- | | |
|---|--|
| <input type="checkbox"/> 2-Way cast boxes | <input type="checkbox"/> Langer® catalogs |
| <input type="checkbox"/> 2-Way multi cast boxes | <input type="checkbox"/> Custom products |
| <input type="checkbox"/> Rx Forms | <input type="checkbox"/> Distribution products |
| <input type="checkbox"/> LANGER <input type="checkbox"/> FIRSTCHOICE <input type="checkbox"/> LXCEL | <input type="checkbox"/> Therapeutic Shoe Bill Information |
| <input type="checkbox"/> Rx repair forms | <input type="checkbox"/> Airborne airbill |

- Please send me the following FREE supplies/information**
- | | |
|--|---|
| <input type="checkbox"/> Post-op recovery shoes | <input type="checkbox"/> Therapeutic hosiery |
| <input type="checkbox"/> CONTOURS prefabs | <input type="checkbox"/> Custom ankle foot orthoses |
| <input type="checkbox"/> PPT® components | <input type="checkbox"/> AFO night splints |
| <input type="checkbox"/> PPT® sheets and materials | <input type="checkbox"/> AFO walkers |
| <input type="checkbox"/> PPT® insoles | <input type="checkbox"/> Custom Birkenstock Catalog |

EXAMINATION FINDINGS

	Right	Left
1st Ray Position		
Plantarflexed (1 st ray cut out)	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>
Dorsiflexed	<input type="checkbox"/>	<input type="checkbox"/>
Hallux Dorsiflexion		
Rigid	<input type="checkbox"/>	<input type="checkbox"/>
Semi-Rigid	<input type="checkbox"/>	<input type="checkbox"/>
Normal	<input type="checkbox"/>	<input type="checkbox"/>
General Foot Motions		
Restricted	<input type="checkbox"/>	<input type="checkbox"/>
Average	<input type="checkbox"/>	<input type="checkbox"/>
Loose	<input type="checkbox"/>	<input type="checkbox"/>
Limb Length Differences		
Right limb is shorter by _____ mm/inches		
Left limb is shorter by _____ mm/inches		
Location of Corns/Calluses R _____		
L _____		

Foot Appearance (non-weight bearing)		
High arch	<input type="checkbox"/>	<input type="checkbox"/>
Medium arch	<input type="checkbox"/>	<input type="checkbox"/>
Low arch	<input type="checkbox"/>	<input type="checkbox"/>
Foot Appearance (weight bearing)		
High arch	<input type="checkbox"/>	<input type="checkbox"/>
Medium arch	<input type="checkbox"/>	<input type="checkbox"/>
Low arch	<input type="checkbox"/>	<input type="checkbox"/>
Subtalar Joint		
Restricted	<input type="checkbox"/>	<input type="checkbox"/>
Average	<input type="checkbox"/>	<input type="checkbox"/>
Loose	<input type="checkbox"/>	<input type="checkbox"/>
Ankle Dorsiflexion		
Adequate	<input type="checkbox"/>	<input type="checkbox"/>
Limited	<input type="checkbox"/>	<input type="checkbox"/>

Knee Position	<input type="checkbox"/> Genu Varum	<input type="checkbox"/> Normal	<input type="checkbox"/> Genu Valgum
Gait Pattern	<input type="checkbox"/> In Toe	<input type="checkbox"/> Normal	<input type="checkbox"/> Out Toe

Subtalar Joint			Forefoot		
	Right	Left		Right	Left
Subtalar Inversion	___°	___°		___° Varus	___° Varus
Subtalar Eversion	___°	___°		___° Valgus	___° Valgus
Subtalar Neutral	___° Varus	___° Varus			
Rested Calcaneal Stance	___	___		Tibial Varum	___° Varus

FOREFOOT EXTENSIONS

From Distal End of Shell To

Sulcus Toes

Thickness

1/8" 1/16"

Materials

PPT®
 PPT®/PLASTAZOTE® (3/16" ONLY)
 PLASTAZOTE®

PADDED TOPCOVERS

Cover From Heel To

Mets Sulcus Toes

Thickness

1/8" 1/16"

Materials

PPT®
 PPT®/PLASTAZOTE® (3/16" ONLY)
 PLASTAZOTE®

DIAGNOSIS/CHIEF COMPLAINT/SPECIAL INSTRUCTIONS

I would like a Professional Account Representative (P.A.R.) to call me.

POSTING VALUES

Post according to lab evaluation of data and cast
 DO NOT post the rearfoot and/or forefoot
 Post to these values instead

	RIGHT	LEFT
REARFOOT	___° Varus	___° Varus
	<input type="checkbox"/> Intrinsic	<input type="checkbox"/> Extrinsic (unless stated otherwise)
HEEL LIFT	___"	___"
FOREFOOT	RIGHT	LEFT
	___° Varus	___° Varus
	___° Valgus	___° Valgus
	<input type="checkbox"/> Intrinsic	<input type="checkbox"/> Extrinsic

Any forefoot post over 5° will be split intrinsic and extrinsic.

Tip Post 1-5 Post Bar

Compressible forefoot post to sulcus
 2-5 Bar post with 1st ray cut out






SHELL MODIFICATIONS/SUBSTITUTIONS


<input type="checkbox"/> Deep Heel Seat	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Cut Orthoses Narrow
<input type="checkbox"/> Lateral Flange	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> WHITMAN ROBERTS
<input type="checkbox"/> Medial Flange	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Schaeffer
<input type="checkbox"/> Reduce Bulk	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Gait Plate to promote
<input type="checkbox"/> Lateral Clip	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Out toe <input type="checkbox"/> In toe
<input type="checkbox"/> SUPERFORM®		<input type="checkbox"/> Heel Stabilizer
<input type="checkbox"/> 1 st Ray Cut Out	<input type="checkbox"/> R <input type="checkbox"/> L	Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
<input type="checkbox"/> KINETIC WEDGE	<input type="checkbox"/> R <input type="checkbox"/> L	


SPECIAL PADDINGS/ACCOMMODATIONS


Arch Reinforcement
 (Standard for patients 275 lbs.+)


PPT® EVA Thermocork


	Right	Left
Neuroma pad	<input type="checkbox"/>	<input type="checkbox"/> 
3rd interspace unless specified		_____
Neuroma plug	<input type="checkbox"/>	<input type="checkbox"/> 
Interspace		_____
Dancer's pad	<input type="checkbox"/>	<input type="checkbox"/> 
Scaphoid pad	<input type="checkbox"/>	<input type="checkbox"/> 
Morton's ext.	<input type="checkbox"/>	<input type="checkbox"/> 

Heel spur pad 

Heel cushion 

2-4 Met pad 

Met bar pad 

Toe crest pad 

Magnetic heel insert

Balance pad (Right) please circle
 1 2 3 4 5

Balance pad (Left) please circle
 1 2 3 4 5

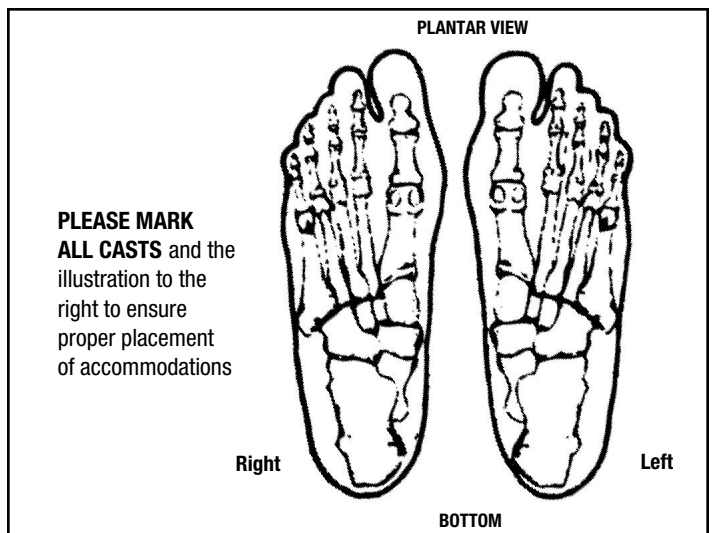
Buttress pad (Right) please circle
 1 2 3 4 5

Buttress pad (Left) please circle
 1 2 3 4 5

Shoes Enclosed R L

SPECIAL COVERING REQUESTS

SPENCO® 1/8" 1/16" Glove leather
 COOLFLEX™ Perforated glove leather
 Medium Density EVA (1/8" only) Suede bottom cover



Please send casts and orders to Langer Inc., where additional supplies and services are also available.

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 450 Commack Road
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