

**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# \_\_\_\_\_      Charge to:     MasterCard     VISA     AmEx     Discover

Money order enclosed      Check# \_\_\_\_\_      # \_\_\_\_\_

Expiration Date \_\_\_\_\_ Signature \_\_\_\_\_

**FUNCTIONAL**

**ACCOMMODATIVE**

**LXCEL F1**  
**Semi-flexible** LANGERFLEX      Vinyl Topcover to Metatarsals  
 3° **Intrinsic** Rearfoot Post

**LXCEL F2**  
**Semi-rigid** LANGERFLEX      Vinyl Topcover to Metatarsals  
 3° **Extrinsic** Rearfoot Post      White Plastic Heel Plate  
**No forefoot posts available**

**Rearfoot posting options**

0°     Intrinsic     Extrinsic      If device is worn in a dress  
 3°     Intrinsic     Extrinsic      shoe, intrinsic rearfoot  
 5°     Intrinsic     Extrinsic      posts are recommended.

**LXCEL A1**  
**Soft** LANGERZORB Foam White Mould to Toes  
 3/16" PPT PLASTAZOTE®  
 (Recommended for patients with diabetes/arthritis.)

**LXCEL A2**  
**Firm** LANGERZORB Foam Black Mould to Toes  
 1/8" Multicolor Medium-Density EVA Topcover  
**No forefoot posts available**

**Rearfoot posting options**

Standard 0° Rearfoot Post  
 3° Intrinsic

**TOPCOVERS AVAILABLE**

**Add PPT® Extension**       **Add PPT® Topcover**       **Replace Standard Topcover with**

Select One      Select One      Select One      Select One

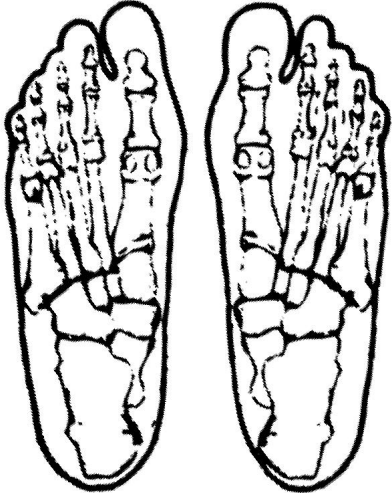
1/16"       Toes       1/16"       Metatarsals  
 1/8"       Sulcus       1/8"       Sulcus  
 Toes       Toes

**3/16" PPT PLASTAZOTE®**  
 **1/8" Multicolor Medium-Density EVA Topcover**  
 **1/8" SPENCO®**

## ACCOMMODATIONS

	RIGHT	LEFT		RIGHT	LEFT		RIGHT	LEFT
Heel spur balance	<input type="checkbox"/>	<input type="checkbox"/>	Neuroma pad	<input type="checkbox"/>	<input type="checkbox"/>	Scaphoid pad	<input type="checkbox"/>	<input type="checkbox"/>
Heel cushion	<input type="checkbox"/>	<input type="checkbox"/>	3rd interspace unless specified _____	<input type="checkbox"/>	<input type="checkbox"/>	Full sole lift 1/8"	<input type="checkbox"/>	<input type="checkbox"/>
Heel lift 1/8"	<input type="checkbox"/>	<input type="checkbox"/>	Neuroma plug	<input type="checkbox"/>	<input type="checkbox"/>	Full sole lift 3/16"	<input type="checkbox"/>	<input type="checkbox"/>
Heel lift 3/16"	<input type="checkbox"/>	<input type="checkbox"/>	Interspace _____	<input type="checkbox"/>	<input type="checkbox"/>	Full sole lift 1/4"	<input type="checkbox"/>	<input type="checkbox"/>
Heel lift 1/4"	<input type="checkbox"/>	<input type="checkbox"/>	Metatarsal pad	<input type="checkbox"/>	<input type="checkbox"/>	Balance pad Right (please circle) 1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>
1 <sup>st</sup> Ray Cut Out	<input type="checkbox"/>	<input type="checkbox"/>	Metatarsal bar	<input type="checkbox"/>	<input type="checkbox"/>	Balance pad Left (please circle) 1 2 3 4 5	<input type="checkbox"/>	<input type="checkbox"/>

### PLANTAR VIEW



**PLEASE MARK ALL CASTS** and the illustration to the right to ensure proper placement of accommodations

**Right**                      **Left**

### BOTTOM

If patient's foot type does not conform to **L.XCEL** specifications, a Langer Professional Account Representative (P.A.R.) will call you.

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

**New York**  
 450 Commack Road  
 Deer Park, NY 11729  
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 Brea, CA 92822  
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 Toronto, ON, Canada M9M2Z3  
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**VISIT OUR WEBSITE**  
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