STRIDE™
CUSTOM ORTHOTICS

FOOT ORTHOSIS DISPENSING FORM

Patient's Name: _____ **Date:** _____

Subjective Report:
Patient's Chief Complaint or Problem: _____

Objective Report: **Orthotic Identification Number:** _____

Orthosis Style Dispensed:

- ❑ Basic Foot Orthotic
- ❑ Extended Basic Foot Orthotic
- ❑ Copoly Foot Orthotic
- ❑ Extended Copoly Foot Orthotic
- ❑ Standard Dress Orthotic
- ❑ Slim Dress Orthotic
- ❑ 2nd Pair (circle one): Dress or Sport
- ❑ Depth Orthotic
- ❑ Extended Depth Orthotic
- ❑ Diabetic Foot Orthotic / Custom
- ❑ Diabetic Foot Insert / Non-Custom
- ❑ Arthritic Specific Foot Orthotic
- ❑ Refurbishment

Posting: Rearfoot Posting ❑ Intrinsic ❑ Extrinsic (Medial or Lateral)
Forefoot Posting ❑ Intrinsic ❑ Extrinsic (Medial or Lateral)
Other: _____

Inlays or Additions to Orthotic:

- ❑ Heel Cushion (L R)
- ❑ Met Bar (L R)
- ❑ MTM (L R)
- ❑ Met Bar with (1 2 3 4 5) MTH Cutout (L R)
- ❑ Heel Lift _____Height (❑ Attached ❑ Unattached) (L R)
- ❑ Other (L R) _____

Orthosis Length: ❑ Met Head ❑ Sulcus ❑ Toes

Top Covers:

- ❑ Vinyl ❑ With Thermosky FF Extension
- ❑ Neolon (1/16" / 1/8") ❑ With Thermosky FF Extension
- ❑ J-Foam (1/16" / 1/8") ❑ With Thermosky FF Extension
- ❑ Plastizote (1/8" / 1/4")

Patient Education: Break-in instructions issued? ❑ Yes ❑ No
Initial break-in (hrs/day): ____ Day 1 ____ Day 2 ____ Day 3

Shoes:

- ❑ New ❑ Existing _____ Size: (Men's / Women's / Child)
- ❑ Athletic ❑ Dress ❑ Oxford ❑ Walking ❑ Work Boot
- ❑ Extra-Depth ❑ Custom Molded ❑ Other: _____
- ❑ Existing Shoes Inappropriate, the following shoes are recommended instead:

_____

Shoe Modifications: ❑ Elevation_____ Height (L R) (❑ Attached ❑ Unattached)

Clinicians Assessment:

Orthosis fit to foot contours:	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Orthosis fit to shoe:	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Patient's initial rating:	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Mechanical alignment with orthosis:	❑ Excellent	❑ Good	❑ Fair	❑ Poor
Prognosis:	❑ Excellent	❑ Good	❑ Fair	❑ Poor

Plan:

- ❑ Orthotics to be worn as per break-in instructions.
- ❑ Orthotic follow-up visit has been scheduled in: ____1wk____2wk____3 wk____PRN
- ❑ Patient is discharged at this time.

Clinician's Signature: _____