STEP004

Stepwell Custom AFO Order Form

Walkwell International Laboratories
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Patient:_____ Date:_____

☐ **Right** ☐ **Left** ☐ **Bilateral** Weight:_____ Shoe Size:_____

Diagnosis:_____

Closure: ☐ Laces ☐ Velcro

Cast Corrections:

Ankle: ☐ Neutral ☐ Pour as is ☐ Other_____

Calcaneus: ☐ Neutral ☐ Pour as is ☐ Other_____

Midfoot: ☐ Neutral ☐ Pour as is ☐ Other_____

Additional Notes/Instructions:_____

Bill To:_____ Ship To_____

Physician's Name:_____ Account #:_____ PO#_____

Casts must be 90° with neutral rearfoot (unless deformity is rigid) and appropriate height to maintain manufacturer's warranty. All casts received plantarflexed or in a valgus /varus position over 15° requesting cast correction to neutral voids warranty. Office will be notified of sub-par casts. Rush surcharge may apply.

FOR LAB USE ONLY

Date Received:_____ Rep #:_____

Date Shipped:_____

Date Office Contacted:_____ Invoice #_____

Additional Charges:_____

Notes:

Right Cast Height_____	**Left Cast** Height_____
°Plantarflexed_____	°Plantarflexed_____
°Dorsiflexed_____	°Dorsiflexed_____
°Valgus_____°Varus_____	°Valgus_____°Varus_____