ORTHOTICA Labs

Repair Work Order

Practitioner ______________________________

Office/Group Name ______________________________

Address ______________________________

____

City/St/Prov ______________________________

Zip/Postal Code ______________________________

Patient ID

Patient Name

Original Order Date _____ / _____ / _________

Sales Order #

☐ ***Do as I instruct*** ☐ ***I need a phone consultation*** ☐ ***Use your discretion*** ☐ ***Refurbish***

Please describe the problem the patient is experiencing: ☐ Right ☐ Left ☐ B/L

____

____

Instructions

____

____

____

Shell Modifications

Narrow device	_____ mm
Widen device	_____ mm
Raise Arch	_____ mm
Lower Arch	_____ mm
Shorten device	_____ mm
Lengthen device	_____ mm

Padding & Thickness

Met Pads	_____L	_____R	_____ B/L	_____1/8	_____3/16
Morton's Ext	_____L	_____R	_____ B/L	_____1/8	_____3/16
Neuroma Pad	_____L	_____R	_____ B/L	_____1/8	_____3/16
Heel Cushion	_____L	_____R	_____ B/L	_____1/8	_____3/16
Heel Spur Pad	_____L	_____R	_____ B/L	_____1/8	_____3/16
Accommodative Pad	_____L	_____R	_____ B/L	_____1/8	_____3/16

Top Cover

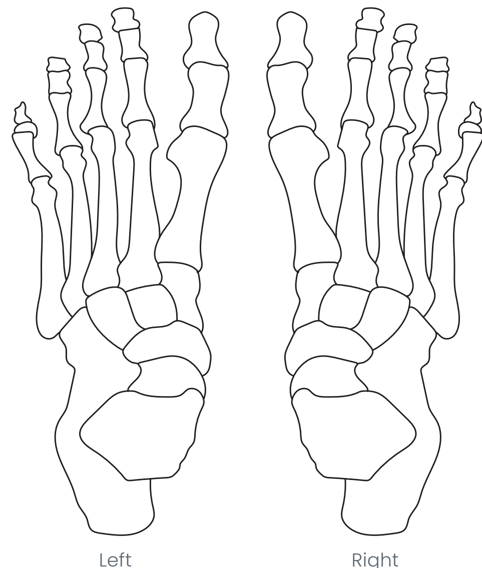
Dual Density	_____ 1/8	_____ 3/16
O Foam	_____ 1/8	_____ 3/16
V Foam	_____ 1/8	_____ 3/16
Neoprene	_____ 1/8	_____ 3/16
EVA Swirl	_____ 1/8	_____ 3/16

Change Length

_____ Met Heads

_____ Sulcus

_____ Toes



Internal Comments

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