The Foot Orthotics Laboratory Custom Appliance Prescription Form

Patient Name:	DOB:
Primary Symptom:	Shoe Size:
Podiatrist Name:	TFOL account number:
Podiatrist address:	

Shell Choice (*please tick*)	
Shell	**Specific Modification (e.g. thinned etc)**
TFOL720	
TFOL722	
TFOL724	

Rearfoot Modification:							
Left				**Right**			
Posting				***Posting***			
Amount: º		Med	Lat	Amount: º		Med	Lat
Int	Hemi	Full Ext	MOSI	Int	Hemi	Full Ext	MOSI
Heel Raise mm				Heel Raise mm			
Rearfoot Shell Shape				***Rearfoot Shell Shape***			
Normal	Incline (skive)	MOSI		Normal	Incline (skive)	MOSI	
Medial	Lateral			Medial	Lateral		
Small	Moderate	Large		Small	Moderate	Large	

Forefoot Modification:							
Left				**Right**			
Amount: º		Med	Lat	Amount: º		Med	Lat
Int		Ext		Int		Ext	

Shell Modification:							
Left				**Right**			
Full Width	Root	Narrow		Full Width	Root	Narrow	
No 1st Ray modification	1st Ray CO	1st MTPJ CO		No 1st Ray modification	1st Ray CO	1st MTPJ CO	
Post Platform Elevation: mm				Post Platform Elevation mm			
Top Cover:	No	Yes Material:		Top Cover:	No	Yes Material:	

Extensions and General Additions / Additional instructions:

Podiatrist/Lab Only	
Orthotic Number:	Patient for exculsive use
Review of prescription completed by:	Orthoses made by:
Labels (Side, pt name,pt ID and 'custom made device') adhered by:	
Advice sheet supplied by:	
Review of final product completed by:	Date:
Additional Podiatrist / Lab Comments if required:	
Signed:	Name Printed: