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www.fdmotion.com

Lab to Call Doctor: Date: _____

Date Received in Lab: _____

SMART BASIC ORDER FORM

Patient Name: _____

Printing Information:

M F DOB: \ \ \

Shoe Size: _____ Weight: _____ Age: _____

Activity Level: 0 1 2 3 4 5

Shoe Type: _____

Occupation: _____

Symptoms/Diagnosis: _____

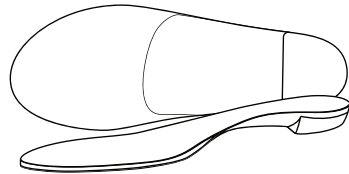
Please fill in the information, or if you have an office label place it here

Doctor's Name: _____

Doctor's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

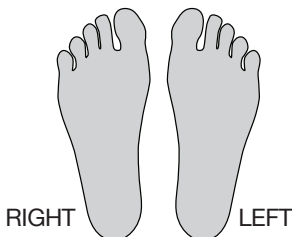


Smart Basic Device
(Limited Accommodations Available)

ADDITIONAL ACCOMMODATIONS:

Use this portion of the form to order additional accommodations.

SHELL MATERIAL	CAST & GRIND	POSTING	COVERING	ACCOMMODATIONS	
<p>Performance RX</p> <input type="checkbox"/> Semi-Flex <input type="checkbox"/> Semi-Rigid <input type="checkbox"/> Rigid	<p>Arch Height</p> <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> No Arch Fill (highest) <p>Heel Cup</p> <input type="checkbox"/> Shallow (10mm) <input type="checkbox"/> Regular (12mm) <input type="checkbox"/> Deep (16mm) <input type="checkbox"/> Other _____ <p>Orthotic Width</p> <input type="checkbox"/> Narrow <input type="checkbox"/> Normal <input type="checkbox"/> Wide/Athletic Cut	<p>Forefoot</p> <input type="checkbox"/> Intrinsic <input type="checkbox"/> No Post <input type="checkbox"/> Extrinsic L _____ Varus/Valgus R _____ Varus/Valgus <p>Rearfoot</p> <input type="checkbox"/> No Post <input type="checkbox"/> Modified Intrinsic <input type="checkbox"/> Extrinsic L _____ Varus/Valgus R _____ Varus/Valgus <input type="checkbox"/> Pronation Skive ___ ° <input type="checkbox"/> Heel Lift ___ mm <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Kirby Skive ___ mm	<p>Top Cover Thickness</p> <input type="checkbox"/> 1/8" <input type="checkbox"/> 1/16" <p>Top Cover Length</p> <input type="checkbox"/> Shell Only <input type="checkbox"/> Sulcus <input type="checkbox"/> Full Length	<p>Met Pad</p> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> 3/16" (Standard) <input type="checkbox"/> 1/8" <input type="checkbox"/> 1/16" <p>Met Bar</p> <input type="checkbox"/> Left <input type="checkbox"/> Right <p>Arch Pad</p> <input type="checkbox"/> Left <input type="checkbox"/> Right <p>1st Ray Cut Out</p> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Cuneiform <p>Morton's Extension</p> <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Reverse <p>Heel Spur Accommodation</p> <input type="checkbox"/> Left <input type="checkbox"/> Right <p>Arch Reinforcement</p> <input type="checkbox"/> Korex <input type="checkbox"/> Poron <input type="checkbox"/> EVA <input type="checkbox"/> Crepe	<p>Metatarsal</p> Left: Right: <input type="checkbox"/> 1 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 5 <p>Other Accomms.</p> <input type="checkbox"/> Heel Cushion <input type="checkbox"/> Hole in Heel <input type="checkbox"/> Horseshoe Pad <p>Amputee Sponge Fill</p> <input type="checkbox"/> Left <input type="checkbox"/> Right



Additional Comments:

Dr. Signature: _____

Order Quantity: _____ Pair

Additional Items: **QTY:**

Shipping Boxes: _____

Foam Impression Boxes: _____

Material Ring: _____

RUSHES

Shipping

Next Day Air \$65.00

Manufacturing

1 Day Rush \$60.00

3 Day Rush \$35.00