

PATIENT INFORMATION

Patient ID*: _____
Age*: _____ **Sex*:** _____
Height*: _____ *ft* _____ *in.* **Weight*:** _____ *lbs.*
Diagnosis:

OTHER INFORMATION

Scanned by (professional)*: _____
Phone (professional)*: _____ **Ext.:** _____
Email (professional)*: _____
Date brace required by customer: _____
PO #*: _____

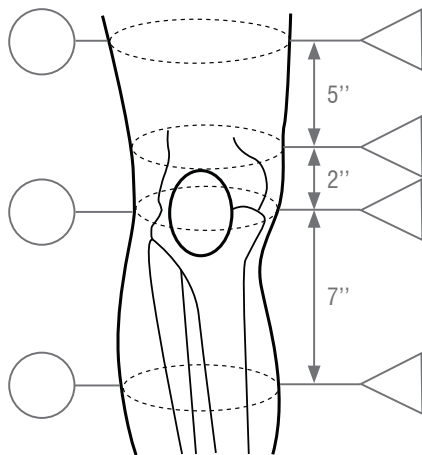
BILLING ADDRESS

Contact*: _____
Company*: _____
Address*: _____
City*: _____
State/Prov.*: _____ **ZIP/P.C.*:** _____

SHIPPING ADDRESS (if different)

Contact*: _____
Company*: _____
Address*: _____
City*: _____
State/Prov.*: _____ **ZIP/P.C.*:** _____

FORM MEASUREMENTS*



Measurements are in*: Inch mm cm

SCANNED OBJECT*

Scan of Leg: with sleeve without sleeve Scan of the Cast

KNEE*

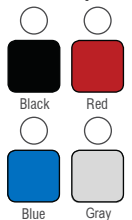
Right Left **Affected ligament:**
 ACL MCL LCL **Torn meniscus:**
 Knee Instability

ASSESSMENT*

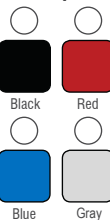
Hyperextension Hyperlaxity Flexum Surgery: _____
 Other: _____

COLORS AVAILABLE

Femoral part*



Tibial part*



OPTION

Condyle pad*:

5mm (default)
 7mm (optional)

SPECIAL NOTES

