

OrderForm

Please apply barcode label here.

P.O.#

Patient First Name:

Patient Last Name:

Gender: _____ Age: _____ Weight: _____

Shoe Size: ** (required) _____ Shoe Style: _____ Insoles Enclosed

PLEASE SEND SOLO Boxes UPS Boxes US Mail Labels
 UPS Labels Order Forms Repair Forms
 Barcoded Address Labels other

DEVICE
 1/8" 4mm **Polypropylene Shell**

PLATE SPECIFICATIONS
Heel Cup 12 mm*
Device Width Bisect 1st Narrow Cut

POSTING

FOREFOOT Intrinsic To Casts*	REARFOOT <input type="checkbox"/> Low Profile
Runner's Wedge <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Intrinsic* <input type="checkbox"/> Extrinsic
Heel Lift <input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> No Post <input type="checkbox"/> To Vertical
<input type="checkbox"/> 1/16" <input type="checkbox"/> 1/8" <input type="checkbox"/> 1/4"	L _____ R _____ varus valgus varus valgus

Shipping Address
If other than
billing address:

City: _____ State: _____ Zip: _____

PAYMENT METHOD Check Enclosed **CK#** _____ \$ _____
 MC Visa AMEX Credit Card on File Bill my SOLO Account

Card #

Name on Card: _____ Exp. Date:

Billing Address: _____
 City: _____ State: _____ Zip: _____

ADDITIONS

Heel Pad Padded Heel Horseshoe Pad L R

Met Pad L R

Scaphoid Pad L R

TOP COVERS

Leatherette* - No Padding
 1/8" Padded Top Cover - On Device Only
 1/8" Padded Top Cover - To Sulcus
 1/8" Padded Top Cover - To Toes

ADDITIONAL PAIR(S) Exact Duplicate(s) Quantity _____
 Other Style(s) Quantity _____
Please include a completed order form for each "Other Style" device ordered.

PREVIOUS ORDER Order # _____ Date: _____

Notes: _____

NOTE: Lab standards will apply when order form is incomplete.
 Standards are designated by **Bold***

Limited Options are available as listed on order form.
 SOLOEssentials are a custom orthotic, molded to a corrected cast.

** If shoe size is not supplied, any/all repair charges if needed will be applied.

Physician's Signature required _____ Date _____