



3D PRINTED SUPRAMALLEOLAR ORTHOSIS

DATE ORDER SUBMITTED _____

PO# _____

Ordering Practitioner

Practitioner _____

Title _____

Company _____

Phone _____

Email _____

Optional Cell _____

Shipping Address

Billing Address (if different than shipping)

Patient Information

Patient Last Name _____

Age _____ Height _____ Weight _____

Diagnosis _____

Foot/Ankle Presentation _____

Left (L) /Right (R) / Bilateral (B) _____

Ankle Alignment

_____ Correct to neutral dorsiflexion

_____ As-is on cast/model – do not correct

Subtalar/Hindfoot Alignment

_____ Correct to neutral (vertical)

_____ As-is on cast/model – do not correct

Forefoot Alignment

_____ Neutral

_____ Varus

_____ Valgus

***1/8 inch P-cell foot bed lining is standard**

Model Submission Method

Capture anatomy in neutral alignment
Photographs are encouraged

_____ **3D Surface Scan (preferred)**

Label STL or OBJ file as PATIENT LAST NAME/PO#

Email with order form to:
david@functionalrestorations.com

_____ **Fiberglass/Plaster Bandage**

(Unfilled)

Email order for prior to mailing model.
Include copy of your order form with model.

Mail to:

Functional Restorations

1821 Hillandale Road

Suite 1B-329

Durham, NC 27705

www.functionalrestorations.com

@functionalrestorations

David Robinson, CCA, CPed

Mobile: 813-810-2807

Email:

david@functionalrestorations.com

Color Choice: _____ Black _____ Blue _____ Pink _____ Grey

Additional Instructions: _____

