



Lab to Call Doctor: Date: _____
 Date Received in Lab: _____

SMART BASIC ORDER FORM

Patient Name: _____

Printing Information:

M F DOB: ____ \ ____ \ ____

914 S. 100 E. Washington, UT 84780

Phone: (800) 301-5835
 (435) 251-8500

Fax: (435) 251-8505

www.fdmotion.com

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: _____

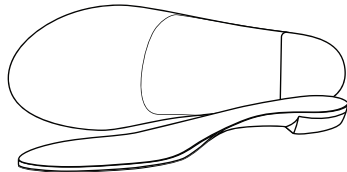
Shoe Size: _____ Weight: _____ Age: _____

Activity Level: 0 1 2 3 4 5

Shoe Type: _____

Occupation: _____

Symptoms/Diagnosis: _____

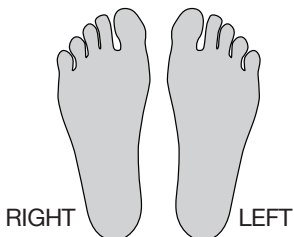


Smart Basic Device
 (Limited Accommodations Available)

ADDITIONAL ACCOMMODATIONS:

Use this portion of the form to order additional accommodations.

SHELL MATERIAL	CAST & GRIND	POSTING	COVERING	ACCOMMODATIONS	
Performance RX™ <input type="checkbox"/> Semi-Flex <input type="checkbox"/> Semi-Rigid <input type="checkbox"/> Rigid	Arch Height <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High <input type="checkbox"/> No Arch Fill (highest) Heel Cup <input type="checkbox"/> Shallow (10mm) <input type="checkbox"/> Regular (12mm) <input type="checkbox"/> Deep (16mm) <input type="checkbox"/> Other _____ Orthotic Width <input type="checkbox"/> Narrow <input type="checkbox"/> Normal <input type="checkbox"/> Wide/Athletic Cut	Forefoot <input type="checkbox"/> Intrinsic <input type="checkbox"/> No Post <input type="checkbox"/> Extrinsic L ____ Varus/Valgus R ____ Varus/Valgus Rearfoot <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	Top Cover Thickness <input type="checkbox"/> 1/8" <input type="checkbox"/> 1/16" Top Cover Length <input type="checkbox"/> Shell Only <input type="checkbox"/> Sulcus <input type="checkbox"/> Full Length	Met Pad <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> 3/16" (Standard) <input type="checkbox"/> 1/8" <input type="checkbox"/> 1/16" Met Bar <input type="checkbox"/> Left <input type="checkbox"/> Right Arch Pad <input type="checkbox"/> Left <input type="checkbox"/> Right 1st Ray Cut Out <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Cuneiform Morton's Extension <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Reverse Heel Spur Accommodation <input type="checkbox"/> Left <input type="checkbox"/> Right Arch Reinforcement <input type="checkbox"/> Korex <input type="checkbox"/> Poron <input type="checkbox"/> EVA <input type="checkbox"/> Crepe	Metatarsal 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 Other Accomms. <input type="checkbox"/> Heel Cushion <input type="checkbox"/> Hole in Heel <input type="checkbox"/> Horseshoe Pad Amputee Sponge Fill (\$15 Additional Fee) <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
 \$75.00

3 Day Rush
 \$45.00