

## PROSTHETIC DESIGN, INC.

CENTRAL FABRICATION

700 Harco Drive ● Englewood, OH 45315 Email: fab@prostheticdesign.com

Fax: (937) 832-5361 • Phone: (937) 836-1464 • Toll Free: (800) 459-0177

## TRANS-TIBIAL SOCKET ORDER FORM

Practitioner Name:   Date:   Phone:   Fax:   Email:   Bill To:	Bill To:  Name	Date: Email:  Shipping is the same as Billing  State Zip
Phone:	Phone: Fax:	Email: Shipping is the same as Billing
Ship To:	Bill To:  Name	Shipping is the same as Billing  State Zip
Name	Name	StateZip
Street Street City State Zip City State Zip Date Required: (Delivery Date Requested)  Patient Name:	Street	State Zip
City State Zip City State Zip  Date Required: (Delivery Date Requested)  Patient Name: Activity Level: Weight: Height: Side: Left Right Bilateral  Shape Capture Method: Cast *Scan: AOP STL OBJ  Height Circumference (Right)	City State Zip City  Date Required: (Delivery Date Requested)  Patient Name: Activity Level: Weight: Side: Left Right Bilateral  Shape Capture Method: Cast *Scan: AOP STL  Height Circumference	State Zip
City State Zip City State Zip  Date Required: (Delivery Date Requested)  Patient Name: Activity Level: Weight: Height: Side: Left Right Bilateral  Shape Capture Method: Cast *Scan: AOP STL OBJ  Height Circumference (Right)	City State Zip City  Date Required: (Delivery Date Requested)  Patient Name: Activity Level: Weight: Side: Left Right Bilateral  Shape Capture Method: Cast *Scan: AOP STL  Height Circumference	State Zip
Patient Name:	Patient Name: Activity Level: Side: Left Right Bilateral  Shape Capture Method:  Height Circumference (Right)  12" 10" 8" 6" 4" 2"	Height:
Activity Level: Weight: Height: Side:	Activity Level: Weight: Side:	Height:
Activity Level: Weight: Height: Side: Left	Cast   Cast	Height:
Shape Capture Method:    Cast *Scan:   AOP   STL   OBJ	Cast *Scan:	
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