

## TRANS-TIBIAL SOCKET ORDER FORM

Please complete entire form.

Company Name: \_\_\_\_\_

Customer PO#: \_\_\_\_\_

Practitioner Name: \_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Bill To:**
**Ship To:** ☐ Shipping is the same as Billing

Name \_\_\_\_\_

Name \_\_\_\_\_

Street \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Date Required:** \_\_\_\_\_ (Delivery Date Requested)

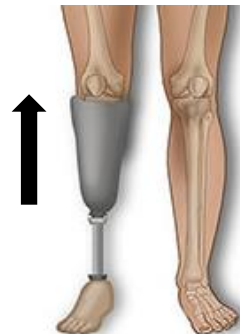
**Patient Name:** \_\_\_\_\_

**Activity Level:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Height:** \_\_\_\_\_

**Side:** ☐ Left ☐ Right ☐ Bilateral

**Shape Capture Method:**
☐ Cast \*Scan: ☐ AOP ☐ STL ☐ OBJ

Height	Circumference (Left)	Circumference (Right)	Reduction
12"			
10"			
8"			
6"			
4"			
2"			

**Record Measurements  
from Distal End:**


### Prosthesis Information

**Locks / Attachment Plates (Suspension method):** \_\_\_\_\_

**Connecting Components:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_