PROSTHETIC DESIGN, INC.
CENTRAL FABRICATION
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Email: fab@prostheticdesign.com
Fax: (937) 832-5361 ● Phone: (937) 836-1464 ● Toll Free: (800) 459-0177

Please complete entire form.

Company Name: _____ Customer PO#: _____

Practitioner Name: _____ Date: _____

Phone: _____ Fax: _____ Email: _____

Bill To:

Name _____

Street _____

City _____ State _____ Zip_____

Ship To: ☐ Shipping is the same as Billing

Name _____

Street _____

City _____ State _____ Zip _____

Date Required: _____ (Delivery Date Requested)

UPS Shipping Method: ☐ Ground ☐ 3rd Day Select ☐ 2nd Day Air ☐ Next Day Air ☐ Next Day Air Saver ☐ Next Day Air Early AM

Patient Name: _____ **Side:** □ Left □ Right **Type:** □ Above Knee □ Below Knee

Activity Level: _____ **Weight:** _____ **Height:** _____

Soft Tissue Amount: ☐ Low ☐ Average ☐ High

Suspension Type: ☐ Locking ☐ Cushion

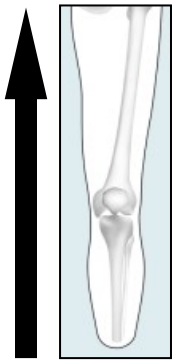
Liner Shape Capture Method: ☐ Cast *Scan: ☐ AOP ☐ STL ☐ OBJ

Record Circumference Measurements from Distal End:
(measurements must be taken seated or lying down)

Loose – measurements with no compression.
Tight – measurements while compressing the soft tissue.

MPT to Distal End: _____
ML at MPT: _____
AP at MPT: _____
Liner Height Requirement: _____

Level	Loose	Tight
16″		
14″		
12″		
10″		
8″		
6″		
4″		
2″		



Notes: _____

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***Please attach files to email addressed to fab@prostheticdesign.com**
***Please attach 4 photos of patient's limb from anterior, posterior, medial and lateral to email**