# Prosthetic Work Order Trans-Tibial

**Office Use Only**

Date Received:_____ Required Landmarks _____

Required Measurements Supplied _____

Workorder Complete _____

Ship To Address: _____

_____

_____

_____

PO # _____ Practitioner Name: _____ Phone Number: _____

Patient Name: _____

Left Right Height _____ Weight _____ Activity Level: 1 2 3 4 Sex: M F

Date Measured: _____ Date Required: _____ Age: _____

**1. Procedure**

- ☐ Test Socket
  - ☐ Clear/PETG
  - ☐ Orfitrans Stiff
- ☐ Definitive Socket

**2. Socket Attachment**

- ☐ None
- ☐ Four Hole Plate
- ☐ Pyramid
- ☐ Other: _____

**3. Suspension**

- ☐ None
- ☐ Friddle's to Supply Lock? Y / N
- ☐ Customer to Supply Lock? Y / N
- ☐ Space for lock only
  - ☐ Bulldog
  - ☐ KISS
  - ☐ 4 Hole
  - ☐ Other: _____
- ☐ Friddle's to supply Expulsion Valve? Y / N
- ☐ Customer to supply Expulsion Vavle? Y / N
  - ☐ Lynn BK
  - ☐ Elevated Type

**4. Insert/Liner Material**

- ☐ None
- ☐ Pelite - add Distal Pad
- ☐ Distal Pad Only
- ☐ Keasy Cone
- ☐ Thermoplastic - Specify Type
  - Final Thickness _____
  - ☐ MPE
  - ☐ Proflex with Silicone
  - ☐ Proflex without Silicone
  - ☐ Other _____

**5. Socket and/or Frame Material**

- ☐ AME/Epoxy
  - ☐ Layup
    - ☐ Std.
    - ☐ Heavy Duty
  - ☐ Finish
    - ☐ Carbon
    - ☐ Decorative Sleeve
    - ☐ PRS Color _____

**6. Cover**

- ☐ Yes
  - ☐ No Skin/Nylons
  - ☐ Spray Skin Y / N
  - ☐ Apply prefab skin Y / N
- ☐ No

FRIDDLE'S ORTHOPEDIC APPLIANCES, INC.

*** Our Guarantee...**
Requires work order, measurements and alignment lines. Accurate and complete data provided by you, shall enhance our mututal goal of "Total" Customer Satisfaction.