New York OMC Plastic AFO Prescription Order Form

1118 Longwood Avenue 2nd FL. Bronx, NY 10474
Phone: (718) 618-7292 ● Fax: (718) 618-0733
www.NewYorkOMC.com Email: Info@NewYorkOMC.com AFO Scans: Scan@NewYorkOMC.com

Date:_____/_____/_____

Bill To:

Account Name:

Address:

City: **State:** **Zip:**

Phone: **Fax:**

Casting Contact:

Email Address:

Ship To:

Ship To Same as Bill Address: ☐

Ship To Address:

City: **State:** **Zip:**

Phone: ( ) **Fax: ( )**

P.O. #:_____

Patient Name:_____ □ Male □ Female Weight:_____ Age:_____

Activity Level: □ Non Ambulatory □ Low / Transfer □ Medium □ High / Active

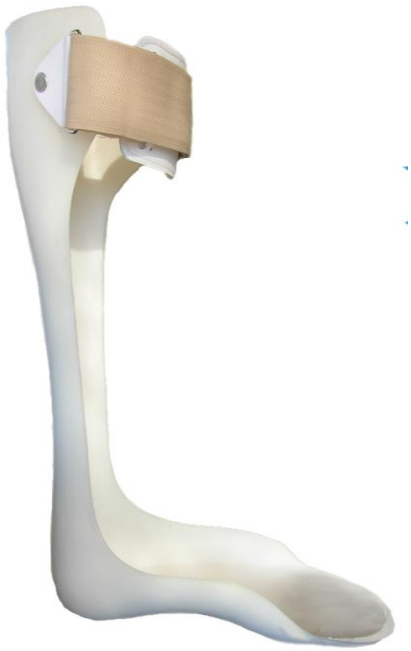
Diagnosis: □ Posterior Tibial Tendon Dysfunction (PTTD) □ Degenerative Joint Disease □ Severe Pronation
□ Trauma □ Other:_____

Primary reason for the Device:_____

Clinical Observation:
Ankle: □ Normal/Flexible □ Limited □ Fixed / Fused **Forefoot**: □Normal / Flexible □ Limited □ Fixed / Fused
Footwear: □ Comfort □ Athletic □ Extra Depth □ Custom Molded □ **Shoe Enclosed**

☐ Left ☐ Right ☐ Bilateral

Style: ☐ SAFO ☐ PLS (Posterior Leaf Spring) ☐ Articulating
☐ Free Motion
☐ Dorsi-Assist
☐ Other



Specify Height: _____ (Measured from base Heel to top of brace)

Color: ☐ WHITE ☐ BLACK ☐ NATURAL

Plastic Thickness: ☐ 5/32" ☐ 1/4" ☐ 3/16"

Lining: ☐ ALIPLAST ☐ PLASTAZOTE ☐ NONE

Footplate Trim Length: ☐ MET ☐ SULCUS ☐ FULL

Lining Extention Length: ☐ MET ☐ SULCUS ☐ FULL

Cast Modifications: ☐ **Use Lab Discretion**
Ankle: ☐ Correct to 90 ☐ Leave as Casted
Forefoot: ☐ Correct to Neutral ☐ Leave as Casted

SPECIAL INSTRUCTIONS

New York Orthopedic Manufacturing Corp.

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