Custom Orthosis Prescription Form

Salfordinsole Healthcare Ltd. **02476 939915**

Please complete this form with care and then send with cast

* Optional

Email: sales@salfordinsole.co.uk

→ Patient Name*: _____

→ or Patient Ref*: _____

→ Ordering Clinic: _____

→ **Order Ref:** _____

Method of providing foot geometry | Foam Box | Sock | Scan | None* | * Select if standard insole is to be used

Post or send via carrier to: **Salfordinsole Healthcare Ltd.**
Unit 27 Centenary Business Centre, Hammond Close, Nuneaton, CV11 6RY

Wedging & Heel Raises

	LEFT FOOT	RIGHT FOOT
◯ Rearfoot Wedge (Specify degrees)	____ Deg ◯ Medial ◯ Lateral	____ Deg ◯ Medial ◯ Lateral
◯ Forefoot Wedge (Specify degrees)	____ Deg ◯ Medial ◯ Lateral	____ Deg ◯ Medial ◯ Lateral
◯ Heel Raise (Specify height)	____ mm	____ mm
◯ Kirby Skive (Specify height)	____ mm ◯ Medial ◯ Lateral	____ Deg ◯ Medial ◯ Lateral
◯ None		

Additions (*mark in foam)

	LEFT FOOT Height			RIGHT FOOT Height		
◯ Cavity*						
◯ Metatarsal Dome*						
◯ Metatarsal Bar*						
◯ Plantar Fascial Groove (Y/N)						

NOTES
Please feel free to send any additional information or instructions.

→ Completed by: .....

→ Contact No: .....

→ Email: .....

→ Date: .....