TCflex AFO SYSTEM CHANGE ORDER

PATIENT INFORMATION

Patient Name________________________________
☐ Male ☐ Female DOB:________________________
Height ______________ Weight________________
Specify Side(s) ☐ Bilateral ☐ Left ☐ Right
Casting Date__________RX____________________

FACILITY INFORMATION

Practitioner____________________PO#__________
Facility_____________________________________
____
Address______________________________________
____
____
Phone________________Fax_____________________

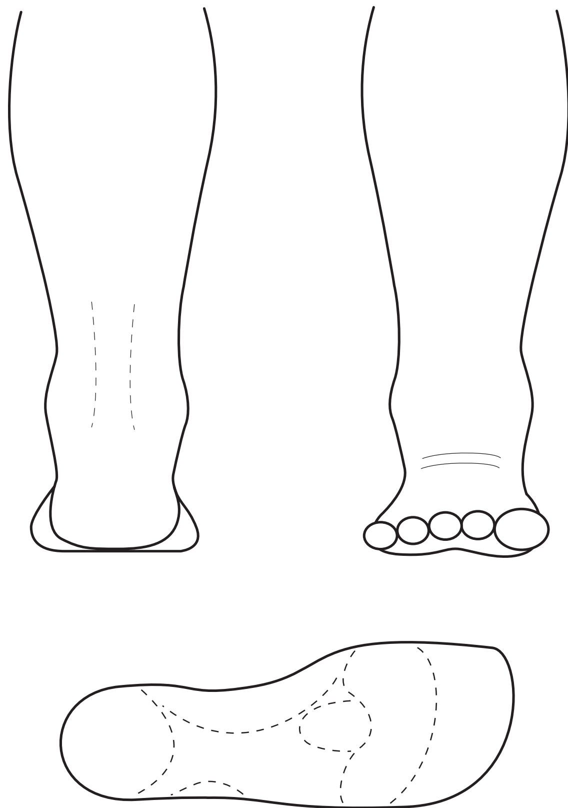
Order / Invoice # ______________________
RA# ____________ CQR# _____________

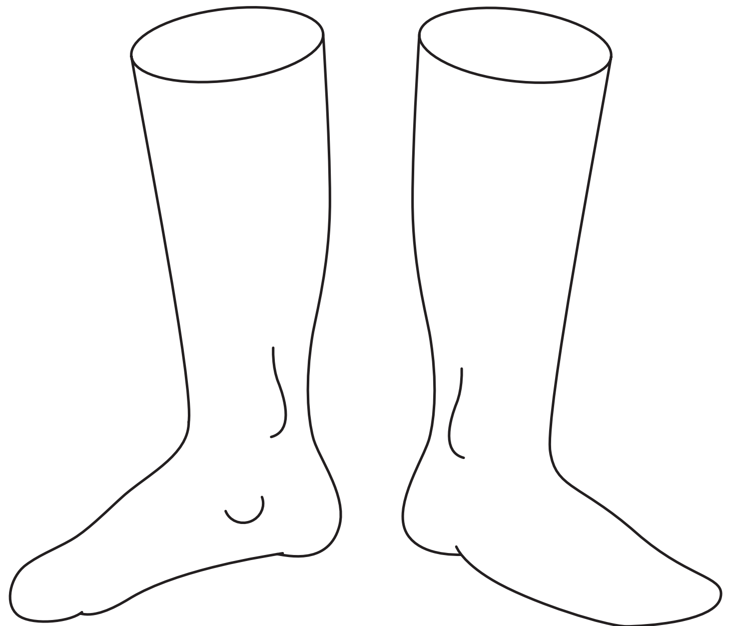
Indicate the area requiring modification:

☐ 1. Forefoot plastic trim
☐ 2. Mid-foot flaps
☐ 3. Height
☐ 4. Length of foot
☐ 5. Met raise
☐ 6. Arch height
☐ 7. Other ____________________________
____
☐ 8. Change design to ____________________

In the space below, please use the number of the location requring modification, then describe the type of modification. For example: 2. Mid-foot flaps are too snug. Add 1/8" more relief over dorsum.

____
____
____
____
____
____
____
____
____





ORTHOMERICA® PRODUCTS, INC.

6333 N. Orange Blossom Trail Orlando, FL 32810
Voice 877-737-8444 Fax 877-737-8445
e-mail custserv@orthomerica.com

TCflex™ AFO SYSTEM

SL 00017 Rev. A