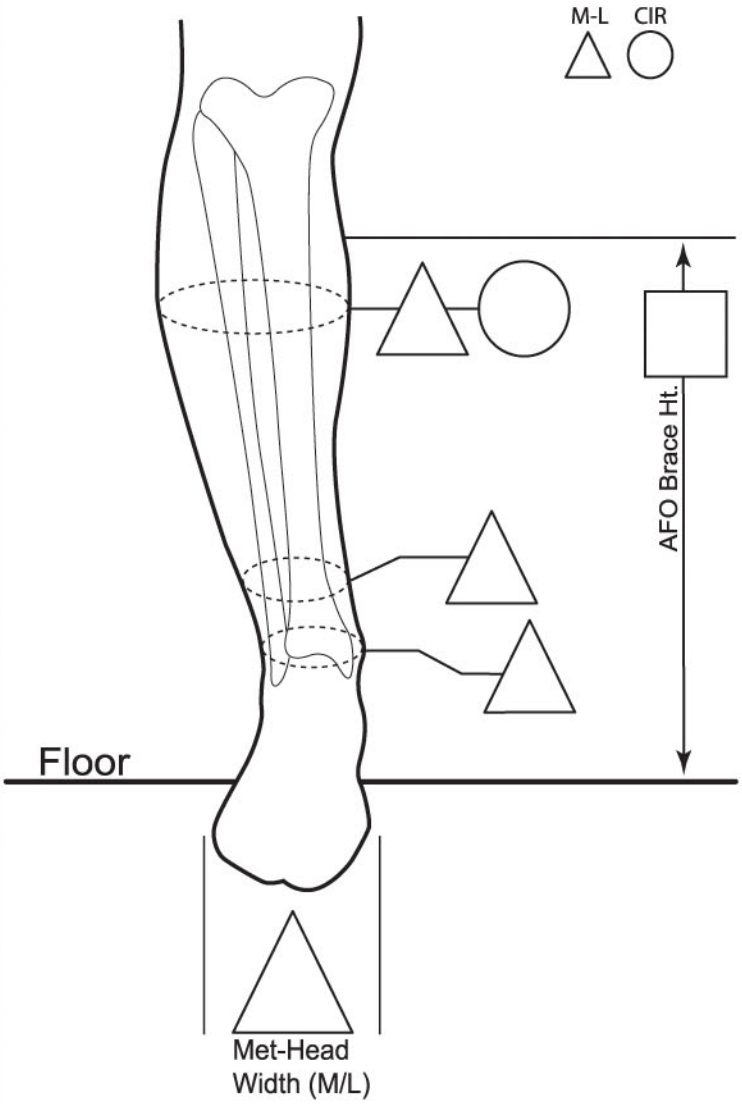
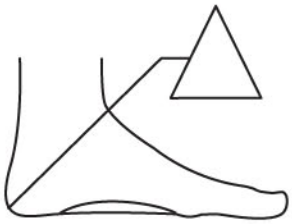
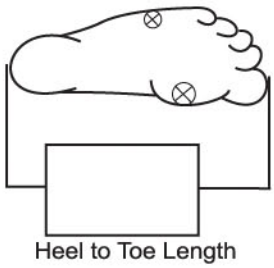
CUSTOM TO CAST/SCAN MEASUREMENT CHART

This chart must be accompanied by TCFlex or AFO - order chart







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_____

Email: _____

Additional Information

_____

_____

_____

_____

_____

_____

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