

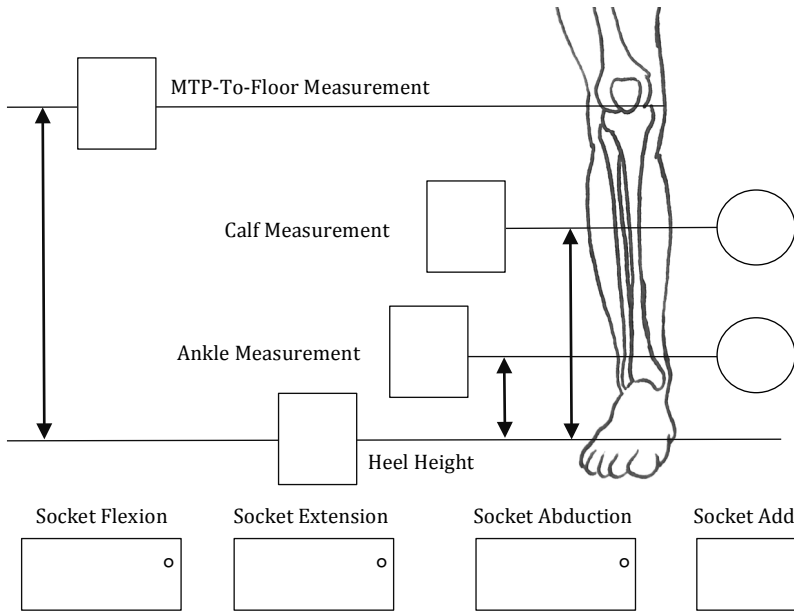
Trans-Tibial Fabrication Order Form

**Please complete the form below. Accurate and careful measurements relate to the fit and function of the device.* PO# _____

Telephone: 651-457-4595
Fax: 651-457-1120

Bill To: _____ Address: _____ _____ Ship To: _____ Address: _____ _____ Practitioner: _____ Phone: _____ Fax: _____ Patient: _____	Patient Information <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Female <input type="checkbox"/> Male Weight: _____ Height: _____ Lamination Color: _____ _____ Otto Bock - Kingsley	Template Provided Positive Cast _____ Check Socket _____ Existing Socket _____ Other: _____ _____
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Measurements



Please illustrate or specify desired trim lines on model, or in additional instructions below.

Additional Instructions:

Fabrication Instructions

Check Socket	
Finish Socket	
Complete Socket Set-Up	
Double Wall/V.A.S.S.	
Exo	Endo
Valve/Suspension	
Static Alignment	
Alignment Transfer	
Carbon Fiber/Special Fabric	
Liner/Soft Insert	
Material:	
Distal End Pad	
Material:	
Foam Cover	
Soft Firm Hose Skin Other	
Laminated Attachment Sleeve	
Velcro	Screws
Other:	

NOTE: A 15% up-charge will be added for ordering parts necessary for completion. Please contact us if parts are needed.

Vertical Mobility Solutions LLC

