

BILLING & SHIPPING INFORMATION

Bill To: **Össur Account #:** _____
IF YOU DON'T HAVE AN ÖSSUR ACCOUNT #, PLEASE FILL OUT FIELDS BELOW

Ship To: Date Needed in Office: _____

Company: _____ Company: _____
Address: _____ Address: _____
City/State/Zip: _____ City/State/Zip: _____
Contact: _____ Contact: _____
Phone: _____ Email: _____ Phone: _____ Email: _____

PO#: _____ Shipping Check Priority: ☐ Next Day Air ☐ 2nd Day (\$8 Flat Rate)

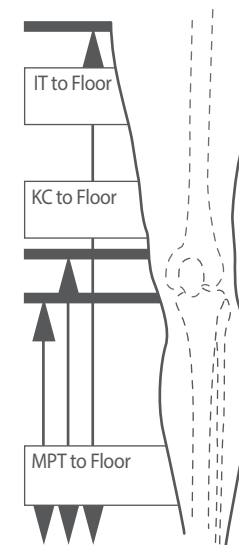
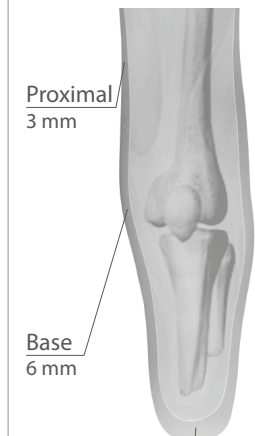
Completion of this order form with the most accurate and up-to-date information, including all patient information, measurements, and construction information enables us to provide the highest quality product for you and your patient.

PATIENT INFORMATION

Patient Name/Reference: _____ Weight: _____
Amputation Level: BK ☐ SYME ☐ AK ☐ KD ☐ Activity Level: 1 ☐ 2 ☐ 3 ☐ 4 ☐ Left: ☐ Right: ☐

CONSTRUCTION

*ITEMS IN BOLD ARE THE DEFAULT SELECTIONS UNLESS OTHERWISE SPECIFIED

MEASUREMENTS		LINERS		ADD WAVE Recommended for TT liners	
	BK AK	Item #	Description	Item #	
	12 _____	<input type="checkbox"/> EVO110	New Evolution Silk Custom Cushion Liner	<input type="checkbox"/> EVO110-W	
	10 _____	<input type="checkbox"/> EVO310	Additional Evolution Silk Custom Cushion Liner	<input type="checkbox"/> EVO310-W	
	8 _____	<input type="checkbox"/> EVO210	New Evolution Silk Custom Locking Liner	<input type="checkbox"/> EVO210-W	
	6 _____	<input type="checkbox"/> EVO410	Additional Evolution Silk Custom Locking Liner	<input type="checkbox"/> EVO410-W	
	4 _____				
	2 _____				
	MPT 0 _____				
	2 _____				
	4 _____				
	6 _____				
	8 _____				
	10 _____				
12 _____					
<input type="checkbox"/> Negative Cast <input type="checkbox"/> Positive Cast <input type="checkbox"/> AOP File * Please cast or scan as high as you would like the liner to be in length. ** Length and circumferences required. If not provided and liner fit requires remake, customer is responsible for cost of remake.		LINER PROFILE 		LINER OPTIONS <input type="checkbox"/> Natural / No silking agent (liner is tacky inside and outside) <input type="checkbox"/> Matrix <input type="checkbox"/> Proximal Lateral Attachments	
Length of Limb: _____		LINER DESIGN <input type="checkbox"/> Standard Design <input type="checkbox"/> Stovepipe <input type="checkbox"/> Fill Invagination <input type="checkbox"/> Add Distal Thickness _____mm		NOTES _____ _____ _____ _____ _____ _____	

Molds retained for two years after last liner order. Two years after last liner order mold will be destroyed.

SEND ALL CASTS, SOCKETS, AND FILES TO: 7199 S CONWAY RD #100 | ORLANDO, FL 32812
TEL (888) 839-6213, FAX (800) 788-9878 | CS@OSSUR.COM

PRINT

SUBMIT TO ÖSSUR