Orthotic Sandal

Prescription Form (v.2)

OLT Footcare
info@oltfoot.com
www.oltfoot.com

PATIENT INFO (Please fill up this form by using a computer)

First Name: _____ ***Last Name***: _____ ***Age***: ____ ***Gender***: ☐Male ☐Female ***Date***: _____

Shoe Size: _____ ☐US ☐EU ***Weight***: ____ ☐lbs ☐Kg

SHIPPING ANDDRESS	**Account/Doctor Info**
Number and Street:	*Doctor Name:*
City:	*Clinic Name:*
State/Province:	*Address:* _____
Zip/Postal Code:	_____
Country:	*City:*_____ *State:*_____
Tel:	*Zip:*_____, *Country:*_____
Email:	*Tel:* *Email:*

Sandal Selection

☐**2-Strap White** ☐**2-Strap Black** ☐**2-Strap Brown** ☐**3-Strap White** ☐**3-Strap Black** ☐**3-Strap Brown**

Sandal Orthotic Prescription

Arch Contact: Minimum ☐ R ☐ L
Standard ☐ R ☐ L
Maximum ☐ R ☐ L

Invert: ☐ 2° ☐ R ☐ L
☐ 4° ☐ R ☐ L

Heel Padding: **2** mm ☐ R ☐ L

Metatarsal Pad: ☐ R ☐ L

Medial Heel Skive: ☐ 2mm ☐ R ☐ L
☐ 4mm ☐ R ☐ L

Heel Lift: ☐ 4mm ☐ R ☐ L
☐ 8mm ☐ R ☐ L

Sandal Lift for LLD: ___ mm ☐ R ☐ L
(To compensate leg length discrepancy)

Padding Full Length: **2** mm ☐ R ☐ L

Laser Engraving Message (max 25 letters)

☐ **Custom Made for [first name initial] [last name initial]**

☐ **Custom Made for [first name]**

☐ **Custom Made for [first name][last name initial]**

☐ _____ (max 25 letters)

Please send your foot castings to one of the locations below.

US: *TDL Systems America Inc*
900 W. Niblick Ct.
Angola, IN 46703
Tel: +1-888-519-3722 x103

CANADA: *TDL Systems Inc*
735 Prince Road, Unit D
Windsor, ON N9C 2Z2
Tel: +1 519 737 7500

Australia: *Runaway Bay Podiatry Clinic*
14/465 Oxley Dr.
Runaway Bay, QLD 4216
Tel: +61 7 5537 9282