



Footlabs

AFO Specification Form

Inv No.

P O No.

Order No.

Patient Details

Name: Hospital / Clinic:

Gender: M F Shoe Make: Clinician:

Shoe Size: Left Right Pair Order Date:/...../.....

ANGLE (As Cast Standard)

As Cast Plantiflexdeg Heel Pitchmm
 Plantigrade (90) Dorsiflexdeg EVA Postmm

CAST RECTIFICATIONS

Neuro Rec 3 Point Pressure Other (please specify)
 ST Rec Valgus Resist
 Peroneal Notch Varus Resist

MATERIAL

Poly Prop 2mm Transfer (please specify)
 Homopolymer 3mm
 Polythene 4.5mm 1st Choice
 Sub-Ortholon 6mm
 Ortholon 2nd Choice

COMPONENTS

Tamarack Hinge Reinforcements
 Metal Free Hinge Compcore
 Other (please specify) Ribbed

STRAPPING

Position	Type (backed reverse pull std)	Sliding Pad
Calf <input type="checkbox"/>	<input type="checkbox"/>
Heel <input type="checkbox"/>	<input type="checkbox"/>
MPJ <input type="checkbox"/>	<input type="checkbox"/>
Other <input type="checkbox"/>	<input type="checkbox"/>

TRIM (please indicate on diagram below)



PADDING

Position	Material (3mm poron std)	Thickness
Malleolus <input type="checkbox"/>mm
Valgus <input type="checkbox"/>mm
Calf <input type="checkbox"/>mm
Full <input type="checkbox"/>mm
Other <input type="checkbox"/>mm

Height mm Length mm

SPECIAL INSTRUCTIONS

Clinician Signature:



Certificate Number 7558
ISO 9001

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MADE IN SHEFFIELD