PLATINUM COLLECTION
AFO REPAIR ORDERFORM

ACCOUNT INFO

Acct # _____
Name _____
Address _____
Phone/Fax _____

Date: __ / __ / _____
PO#: _____

LAB USE ONLY ❑ PPD ❑ BF
L _____ R _____ ONLY_____
OE_____

PATIENT INFO
Please Print (all patient info is required)

First Name:_____Last Name:_____ D.O.B.:___/___/___
Weight:_____ ☐M ☐F Shoe Size:_____ Shoe Style:_____
Width: ☐ Narrow ☐ Medium ☐ Wide Shoes Provided: ☐ Yes ☐ No

ORDER OPTIONS
(Additional Charges May Apply)

☐ RUSH Order ($35) ☐ Ship Overnight ($35) ☐ Ship to Patient ☐ International Shipping
(Additional $3 Shipping Charge - Indicate address in Patient Info)

SIGNATURE: *Physician Signature Required for Mediacare Claims*
_____

INSTRUCTIONS

FOREFOOT POSTING
Raise
☐ Sulcus Wedge Extrinsic
☐ Add
☐ Remove
_____ L ☐ Varus _____ R
_____ L ☐ Valgus _____ R

REARFOOT POSTING
Extrinsic
☐ Extrinsic rearfoot posting accord. to measurements:
_____L ☐ Varus ____ Motion
☐ Valgus
_____L ☐ Varus ____ Motion
☐ Valgus

UPRIGHT SHELL
L R
___ ___ Plastic to Graphite
___ ___ Graphite to Plastic

PIVOT
L R
___ ___ Functional Flex
___ ___ Temporarily Fixed 90
___ ___ Permanently Fixed 90
___ ___ Dorsi-Assist

EXTENSIONS

MATERIAL
Implus - Available in 1/8" only.	☐ Add	☐ Remove
NeoStride - Available in 1/8" only.	☐ Add	☐ Remove
Plastazote/PPT Total 1/4" thickness.	☐ Add	☐ Remove
EVA Swirl	☐ Add	☐ Remove

LENGTH
☐ Cover the ends of toes	☐ Add	☐ Remove
☐ Cover to sulcus	☐ Add	☐ Remove
☐ Cover orthosis only	☐ Add	☐ Remove

POCKET
L R
___ ___ As marked on cast ☐ Add ☐ Remove

L R
___ ___ Horseshoe Heel Pocket ☐ Add ☐ Remove

ACCESSORIES

L R
___ ___ **2001 Accom.** Marked in forefoot only.
___ ___ **Amputation Fill** Shoes required.
☐1st ☐2nd ☐3rd
☐4th ☐5th ☐Transmet
___ ___ **Arch fill**
☐Prolite STD ☐Korex
___ ___ **Arch raise (pad)**

L R
___ ___ **Cuboid Pad**
___ ___ **Heel Cushion**
___ ___ **Heel Cushion w/Center Pocket**
___ ___ **Heel Lift**
☐1/4"STD ☐1/8"
___ ___ **Horseshoe Heel Cushion**

L R
___ ___ **Lateral Wedge**
___ ___ **Medial Flap**
___ ___ **Met bar** (1-5)
Met pad
___ ___ ☐#22(s) ☐#40(m) ☐#351(lg)
___ ___ ☐Bevel to 1/8" thickness

REPAIR

☐ **Recover** ☐ As Is ☐ As Is With Changes
☐ **Complete Refurbishment**

REPLACEMENT COMPONENTS
L R
___ ___ Full-Length Pads
___ ___ Gel Pads
___ ___ Staps

L R
___ ___ Plastazote/PPT Upright Pads
___ ___ U Pads
___ ___ Topcover

HEATING

L R
___ ___ Lower arch 1/8"
(if more than 1/8" is needed, a remake is necessary.)
___ ___ Raise arch 1/8"
(if more than 1/8" is needed, add arch raise (pad).
___ ___ Stirrup: Lateral ☐In ☐Out
___ ___ Stirrup: Medial ☐In ☐Out

GRINDING

L R
GRINDING WIDTH
___ ___ ***Narrow shell by:** ☐1/8" ☐3/16" ☐1/4" ☐FF ☐Heel ☐Arch ☐Entire Device
___ ___ **Widen shell by:** ☐1/8" ☐3/16" ☐1/4" ☐FF ☐Heel ☐Arch ☐Entire Device

SHELL MODIFICATIONS
___ ___ **1st Ray Cutout** ☐Add
___ ___ **Deep Heel Cup** N/A on System 3.0 or TL ☐Remove
___ ___ **Shaffer Medial** ☐Remove

* If othoses is too narrow or to short, a remake is necessary. Some grinding modification will require a remake.

NOTES:
_____
_____
_____
_____
_____
_____
_____
_____

Need Supplies? **JOIN OUR PORTAL AT XTREMITY3D.COM**

PAL HEALTH TECHNOLOGIES
1805 Riverway Dr. Pekin, IL 61554 | 800.223.2957 | Fax: 866.381.3850
XTREMITY3D.COM

POLICIES & PROCEDURES

Effective May 1, 2010
Prices listed in US$ Call for prices in Canada

Ordering Information
Call PAL to request product literature and a shipping kit. We'll include order forms, boxes, and preprinted labels – everything you need to begin ordering!

Orders MUST INCLUDE a negative cast with the following markings:
- Bisection of 1st and 5th metatarsals
- Most inferior aspect of lateral and medial malleoli
- Base of the 5th metatarsal (styloid process) if a lateral flange is requested.
- Markings should be made directly on the foot in felt tip (transferrable ink) marker while the foot is held as close to 90° **to the lower** limb as possible.
- Casts should be taken using a suspension non-weight bearing technique with patient in subtalar neutral and midtarsal joint held fully loaded and locked.
- The ankle should be in the maximal dorsiflex position without the patient's assistance.
- Plaster should be well rubbed and smoothed onto foot to capture the maximum detailed features of the foot and ankle. The calcaneal body and malleoli contours are most critical.

Orders received by PAL NOT MEETING the above standards WILL NOT be processed until the standards are met.
- Re-casts will be required for unmarked, improperly marked or general poor condition casts.

Biomechanical Consultations
With more than 60 years of combined biomechanical expertise, you can expect outstanding customer service from PAL.

PAL Customer Service: 800.223.2957

Cast Storage
- Brace casts are stored for **three (3) months** from the date of original shipment.

Standards
Standard cast corrections include minimal arch fill and 1/8'' heel expansion. Please request additional arch fill if patient is known to be intolerant of high or tightly conforming arched devices.

Terms
Full payment is due on the 15th of the following month. Service will be suspended for delinquent accounts until the past due amount is paid.

For questions, call: 800.223.2957

Reminder
FOR MEDICARE CLAIMS, signature of prescriber is required. Please provide signature in "NOTES" section on the front side of this order form.

Warranty
- For Accommodative, Advantage+ and Platinum Brace, workmanship and defects in material are guaranteed for three (3) months from the original ship date.

Repairs & Adjustments
- All heating and grinding adjustments will be at no charge within the Warranty period.
- Items added during the Warranty period will be subject to charges.
- PAL reserves the right to limit the adjustments available on Competitor devices.

Returns
- All braces are fabricated to a prescription and cannot be returned for credit; however, PAL will advise you on specific adjustments.

Supply Requests
To request additional supplies, including order forms, please call (800) 447-0151 or visit our website: www.palhealthtech.com

Suggested Base L-Codes
L1970 - AFO plastic molded to patient's model with ankle joint

Suggested Accessory L-Codes
L2820 - Below-the-knee soft interface

L2210 - Addition to lower extremity, dorsiflexion assist/plantar flexion resist ankle joint

L2275 - Modified footplate

L3002 - Plastazote/PPT foot insert; removable; molded to patient model

L3020 - Metatarsal pad; longitudinal/metatarsal support

L3410 - Metatarsal bar

L3420 - Heel lift

L3480 - Heel cushion with center pocket

L3485 - Horseshoe pad

L5000 - Toe filler

Additional Charges
There may be additional charges to the client for the following special requests:
- Ship to patient
- Return Casts
- Return Shoes
- Rush
- Alternate shipping methods
- COD