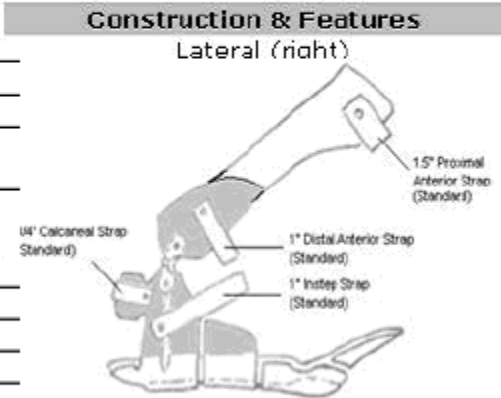




KineMedic Concepts, Inc.  
 P.O. Box 3220 Blue Jay, CA 92317  
 Phone: (909) 337-3449  
 Fax: (909) 498-0300  
 Web: www.KineMedic.com

## Perfect Response Orthotic<sup>(R)</sup> Order Form

**Patient Information**  
 Patient's Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Specify Side(s): \_\_\_\_\_  
 Bilateral  Left  Right  
 Date Cast: \_\_\_\_\_



**Facility Information**  
 Practitioner: \_\_\_\_\_  
 Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Email Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_

**Note: The standard option will be provide when no option has been selected**

**Referring Therapist**  
 Name: \_\_\_\_\_

Posterior Height	<input type="checkbox"/> Standard 2/3 leg height
	<input type="checkbox"/> Specified on cast
Eversion Assist	<input type="checkbox"/> Very Flexible
	<input type="checkbox"/> Standard Moderate
	<input type="checkbox"/> Semi Rigid
Padding	<input type="checkbox"/> Standard (shaded area)
	<input type="checkbox"/> Additional (note below)
Straps	<input type="checkbox"/> Standard (above)
	<input type="checkbox"/> Additional MP strap
Ankle Joints	<input type="checkbox"/> Tamarack Dorsi L75 Mild Standard
	<input type="checkbox"/> Tamarack Dorsi L85 Moderate
	<input type="checkbox"/> Tamarack Dorsi L95 Strong

**Shipping Information**  
 Shipping Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Special Instructions**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The recommended position is as follows: ankle in 5 degree dorsiflexion, the hindfoot in neutral, the midfoot and forefoot positioned toward eversion, with the toes in 15-30 degree extension. Our lab staff can help to refine minor corrections required, however, the more likely anatomical subtleties will be lost, resulting in fit problems. If the ankle, hindfoot, midfoot and forefoot alignment can be significantly improved with a recasting, we believe this is by far the most efficient first step in correcting a cast. It is important that any RDM limitations be understood and accounted for in the corrections you request.

**CAST CORRECTION - POSITION OF FUNCTION**  
**\* MUST BE COMPLETED TO PROCESS ORDER \***

**ANKLE ALIGNMENT (Dorsiflexion - Plantarflexion)**  
 Correct to \_\_\_\_\_°  Do Not Correct (Cast Alignment OK)

**HINDFOOT ALIGNMENT**  
 Correct to Vertical (if Misaligned)  Do Not Correct (Cast Alignment OK)

**FOREFOOT ALIGNMENT** NOTE: Drawings Depict Finished Position  
 1. Check box below to indicate required forefoot alignment.  
 2. Include height at Met. Head for varus or valgus choices (in inches).

RIGHT FOOT	LEFT FOOT
<input type="checkbox"/> Do Not Correct (Cast Alignment OK)	<input type="checkbox"/> Do Not Correct (Cast Alignment OK)
Correct to _____	Correct to _____

**Please Send Casts to P.O. Box 3220 Blue Jay, CA 92317 if using USPS.  
 If using UPS/FedEx/DHL please send cast to 481 Golf Course Road,  
 Lake Arrowhead, CA 92352**