


### SHOE MODIFICATION ORDER FORM



Patient Information	Health Practitioner Information
Name: _____ Shoe Size: _____ Age: _____ Gender: M / F Height: _____ Weight: _____ Symptoms: _____ _____ _____	Name: _____ Address: _____ _____ Phone #: _____ Diagnosis: _____

Type of Modification						
Stretching R / L <i>Note where &amp; how much</i>	<input type="checkbox"/> Ball & Ring _____		<input type="checkbox"/> Upper (width) _____		<input type="checkbox"/> Vamp (raise) _____	
Rocker Soles	<input type="checkbox"/> Mild Rocker Sole (all)	<input type="checkbox"/> Toe-Only	<input type="checkbox"/> Negative Heel		Description:	
	<input type="checkbox"/> Heel-to-Toe	<input type="checkbox"/> Severe Angle	<input type="checkbox"/> Double Rocker			
Elevations in inches	<input type="checkbox"/> 1/16" Right / Left	<input type="checkbox"/> 1/8" Right / Left	<input type="checkbox"/> 1/4" Right / Left	<input type="checkbox"/> 1/2" Right / Left	<input type="checkbox"/> 1" Right / Left	<input type="checkbox"/> > 1" _____
Stabilization	<input type="checkbox"/> Medial Flare <input type="checkbox"/> Right Shoe <input type="checkbox"/> Left Shoe notes:		<input type="checkbox"/> Lateral Flare <input type="checkbox"/> Right Shoe <input type="checkbox"/> Left Shoe notes:		<input type="checkbox"/> SACH Heel <input type="checkbox"/> Right Shoe <input type="checkbox"/> Left Shoe notes:	
Fillers	Transmetatarsal amputation <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot notes:		1 <sup>st</sup> ray hallux digital amputation <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot notes:		5 <sup>th</sup> digital / lateral column amputation <input type="checkbox"/> Right Foot <input type="checkbox"/> Left Foot notes:	
			Indicate which digits to be filled for amputation fillers and/or where you would like deflections to be placed (i.e. for ulcers or pressure points)		Additional Comments: _____ _____ _____ _____	

**PLEASE NOTE THAT FOR ALL FOOTWEAR SENT FOR MODIFICATION THAT IS NOT MANUFACTURED BY DR. COMFORT AND/OR NOT DEEMED ORTHOPAEDIC (AT DISCRETION OF SIMS) WILL BE CHARGED A \$10 PREMIUM PER ORDER. SIMS MEDICAL DOES NOT WARRANTY ANY WORK PERFORMED ON FOOTWEAR THAT IS NOT DR. COMFORT. ANY MODIFICATIONS ON DR. COMFORT FOOTWEAR ARE WARRANTIED FOR 3 MONTHS FROM THE DATE OF ORIGINAL INVOICE.**