

PATIENT INFORMATION	OTHER INFORMATION
Patient ID*: _____ Age*: _____ Sex*: _____ Height*: _____ <i>ft</i> _____ <i>in.</i> Weight*: _____ <i>lbs.</i> Diagnosis: _____ _____	Scanned by (professional)*: _____ Phone (professional)*: _____ Ext.: _____ Email (professional)*: _____ Date brace required by customer: _____ PO #*: _____

BILLING ADDRESS	SHIPPING ADDRESS (if different)
Contact*: _____ Company*: _____ Address*: _____ City*: _____ State/Prov.*: _____ ZIP/P.C.*: _____	Contact*: _____ Company*: _____ Address*: _____ City*: _____ State/Prov.*: _____ ZIP/P.C.*: _____

FORM MEASUREMENTS*

Measurements are in*: Inch mm cm

SCANNED OBJECT (BK SOCKET SETUP STYLE)*

Scan of Leg: with suspension sleeve
 direct-to-socket *(Note: scan with stockinette over socket)*

KNEE*

<input type="checkbox"/> Right	Affected ligament: <input type="checkbox"/> ACL <input type="checkbox"/> MCL <input type="checkbox"/> LCL <input type="checkbox"/> Knee Instability	Torn meniscus: <input type="checkbox"/>
<input type="checkbox"/> Left		

ASSESSMENT*

Hyperextension
 Hyperlaxity Flexum Other: _____

COLORS AVAILABLE	OPTION	SPECIAL NOTES				
<table border="0"> <tr> <td>Femoral part*</td> <td>Tibial part*</td> </tr> <tr> <td> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Black <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Gray </td> <td> <input type="radio"/> <input type="radio"/> <input type="checkbox"/> Black <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Gray </td> </tr> </table>	Femoral part*	Tibial part*	<input type="radio"/> <input type="radio"/> <input type="checkbox"/> Black <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Gray	<input type="radio"/> <input type="radio"/> <input type="checkbox"/> Black <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Gray	Condyle pad*: <input type="checkbox"/> 5mm (default) <input type="checkbox"/> 7mm (optional)	_____ _____ _____ _____
Femoral part*	Tibial part*					
<input type="radio"/> <input type="radio"/> <input type="checkbox"/> Black <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Gray	<input type="radio"/> <input type="radio"/> <input type="checkbox"/> Black <input type="checkbox"/> Red <input type="checkbox"/> Blue <input type="checkbox"/> Gray					