SOLO LABORATORIES, INC.

LIMITED

PLACE ACCOUNT LABEL HERE

PATIENT INFORMATION

Patient Name

Shoe Size* ☐ **Male** *(Size)* ☐ **Female** *(Size)*

/ /

Date of Birth *(MM / DD / YYYY)*

☐ Shoes / Insoles Enclosed

/ /

Previous Rx# Date *(MM / DD / YYYY)*

RUSH UPGRADE

☐ **Next Business Day**

☐ **OVERNIGHT SHIPPING**
RUSH CHARGES DO NOT INCLUDE OVERNIGHT SHIPPING

☐ **Mail-to-Patient**
INCLUDE SHIPPING ADDRESS (TO THE RIGHT)

P.O. Number

SHIPPING INFORMATION IF SHIP TO PATIENT OR LOCATION OTHER THAN BAR CODE.

Shipping Street Address

City State Zip

Physician's Signature

SOLO will automatically upgrade your order to a Premier when you request options not listed on this form. Additional charges will apply.

CHOOSE POLYPROPYLENE SHELL RIGIDITY

☐ Flexible
☐ **Semi-Rigid**
☐ Rigid

Weight
REQUIRED

HEEL LIFT CREPE

☐ 1/8" Left Lift	☐ 3/16" Left Lift	☐ 1/4" Left Lift
☐ 1/8" Right Lift	☐ 3/16" Right Lift	☐ 1/4" Right Lift

HEEL DEPTH

X-Deep ☐
Deep ☐
Standard ☐

MET PAD

☐ Left Met Pad
☐ Right Met Pad

SHELL WIDTH

☐ **Standard** (bisect 1st)
☐ Narrow

Standard
Narrow

1st MET CUT OUT

☐ Left Met Cut Out
☐ Right Met Cut Out

TOP COVER MATERIAL AND LENGTH

☐ **Leatherette to Mets**
☐ 1/8" EVA to Mets
☐ 1/8" SILPURE® to Mets
☐ 1/8" EVA to Toes
☐ 1/8" SILPURE® to Toes

POSTING REARFOOT

☐ Intrinsic *(Rear)*
☐ **Extrinsic** *(Rear low profile)*

☐ **To Vertical** *(Rear)*

Left Varus ______ Right Varus ______
Left Valgus ______ Right Valgus ______

No substitutions or modifications will be accepted.
Lab Standards in BOLD will be applied.

Images are for visual purposes only.
*If shoe size is not supplied, any repair charges needed will be applied