## CUSTOMER INFORMATION

Clinician Name

Preferred Contact Method

O Phone：
O Email Address：

Facility／Clinic：
Bill to Account \＃： $\qquad$ PO \＃ $\qquad$
Shipping Address Line 1：
Shipping Address Line 2 ：

## SHIPPING AND PATIENT INFORMATION

Carrier：Method：
○ UPS
○ Ground
O－Day
O－Day
$\bigcirc$ FedEx
O Next Day
O Next Day Saver

Amputation Side：
Amputation Level：
O Left
$\bigcirc$
Bilateral
＊Requires separate order forms． Indicate side on each form
$\bigcirc$ TF ○ KD

Patient ID／Last Name：

## Height：

$\qquad$ ft $\square$
in

K－Level：
Weight： $\qquad$ lbs

○ K1 ○ K3
OK2 ○ K4

## PATIENT MEASUREMENTS



