



FOR INTERNAL USE ONLY

WORK ORDER NUMBER _____

SHOE AND ORTHOTICS ORDER FORM

BILLING ADDRESS:

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Purchase Order: _____

SHIPPING ADDRESS:

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Email: _____

SHIPPING METHOD (circle choice): **FED EX** 1 day 2 day Ground **UPS** 1 day 2 day 3 day Ground**PATIENT/SHOE ORDERING INFORMATION**

Patient Name: _____ Sex: _____ Age: _____ Weight: _____ lbs.

Ordering: Shoe Size: _____ Width: _____ Shoe Style: _____ Shoe Color: _____

Diagnosis: _____

Additional Instructions: _____

SOLE DEFENSE SHOE SIZING

Specify Width with order.

Med = A, B, C

Wide = D, E

XWide = EE, EEE

(HALF SIZES AVAILABLE)

ACTIVZ™ (limited supply available)White MEN: 3-12, 13, 14
WOMEN: 5-14, 15, 16**BROADWAY™**Black MEN: 3½-12, 13, 14
WOMEN: 5½-14, 15, 16
Mocha MEN: 4-8, 9
WOMEN: 6-10, 11**COMFORT STREET™**Black, Bone MEN: 3-12, 13, 14
WOMEN: 5-14, 15, 16**RIVER WALK™**Black MEN: 3-12, 13, 14
WOMEN: 5-14, 15, 16
Bone, Mocha MEN: 3-9, 10
WOMEN: 5-11, 12**SPRING STREET™**Black Leather, Bone Leather, Brown Nubuck
MEN: 3-12, 13
WOMEN: 5-14, 15
Black Nubuck, Tan Nubuck, White Leather
MEN: 3-9, 10, 11
WOMEN: 5-11, 12, 13**A5513 CUSTOM INSOLES* (SADMERC REVIEWED)**

Item Number	Description	QTY in PAIRS
CORT-96	P-Cell® + Microcel Puff®	
CORT-98	P-Cell® + MultiCork™	
CORT-9P6	P-Cell® + PORON Medical® Urethane + Microcel Puff®	
CORT-X16	X-Static® lined Impression Puff™ + Microcel Puff®	
CORT-X18	X-Static® lined Impression Puff™ + MultiCork™	
CORT-X1P6	X-Static® lined Impression Puff™ + PORON Medical® Urethane + Microcel Puff®	
CORT-6P6	Microcel Puff® + PORON Medical® Urethane + Microcel Puff®	
CORT-9P8	P-Cell® + PORON Medical® Urethane + MultiCork™	
CORT-6P8	Microcel Puff® + PORON Medical® Urethane + MultiCork™	

FOR BEST VALUE:

*A5513 sold in groups of three (3) pairs in full length only

Included: Impression Foam, Mailing Carton, and Self-Addressed Postage Label

INSTRUCTIONS

- PLEASE FILL OUT THE FORM COMPLETELY.
- SHOE STYLE **MUST INCLUDE:** SIZE, WIDTH, STYLE, COLOR, AND GENDER.
- CAST PATIENT FOR ORTHOTICS. (FOLLOW INSTRUCTIONS ON BACK)
- PLACE FORM IN THE IMPRESSION FOAM BOX.
- ATTACH PRE-PAID MAILING LABEL TO OUTER CARTON.
- MAIL PACKAGE TO:

ACOR ORTHOPAEDIC, INC.
18530 South Miles Parkway
Cleveland, OH 44128
ATTN: CUSTOM PRODUCTS

IF NOT ORDERING SHOES, PLEASE SUPPLY THE FOLLOWING INFORMATION:

MANUFACTURER: _____ SIZE: _____ WIDTH: _____

TOE SHAPE: OBLIQUE _____ STANDARD _____

COMPLETE LINE OF DREW + ORTHOFEET SHOES AVAILABLE FOR ORDERING!

FORM-0002

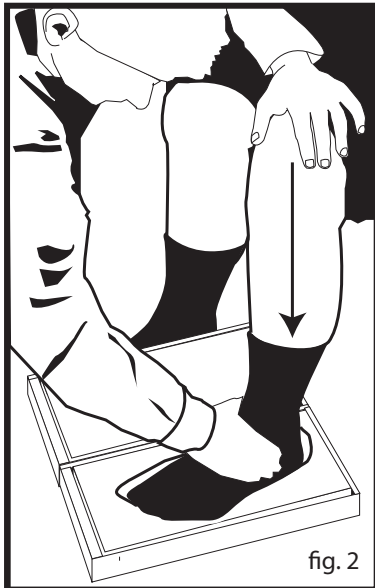
18530 South Miles Pkwy • Cleveland, OH 44128 • ph: (800) 237-2267 (OPTION 2) • www.acor.com

FOR OFFICE USE: LEFT _____ RIGHT _____ PAIR _____ FI SC CS PC FC

CASTING INSTRUCTIONS FOR THE A5513 CUSTOM ORTHOTICS

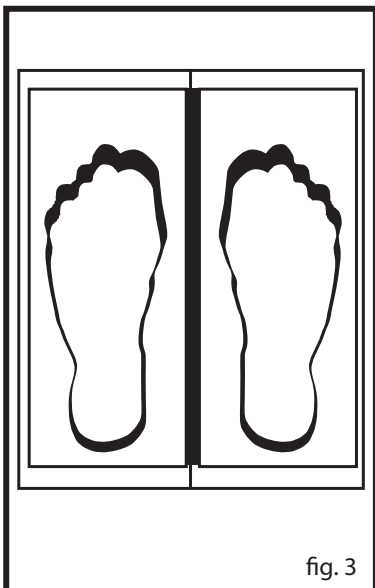


1. Seat the patient near the edge of a chair so that both feet are resting flat on the floor. They should leave their socks on and make sure the socks are pulled up to avoid wrinkles showing in the foam. Place one foot gently on the foam with the hip, knee and ankle at 90 degrees as viewed from the side. (See figure 1)



2. Have patient relax. Using downward pressure on the knee and the foot, with your right and left hands, push the foot evenly and completely into the foam. Make sure the toes are not touching the edge of the box, as shown. (See figure 2)

3. Repeat steps 1-2 with the opposite foot. The impressions will end up in opposite directions. (See picture 3)



4. Fill out form on the opposite side completely and return with foam box and pre-paid shipping label.

ACOR®

18530 South Miles Parkway, Cleveland, Ohio 44128
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www.acor.com email@acor.com