



Aligner AFO Order Form

5513 WEST SLIGH AVE, TAMPA FL 33634-4431

PHONE: 800-919-3668 FAX: 888-484-5927 WWW.KINETICRESEARCH.COM EMAIL: EMAIL@KINETICR.COM

Company: _____

Location: _____

PO#: _____

Date: _____ Date due: _____

Practitioner: _____

Patient name: _____

Age: _____ Height: _____ Weight: _____

Male Female

Activity level: _____

Pathology: _____

Cast position: _____

Correct to: _____

All casts will be corrected to 90 degrees on a 3/8" heel height and subtalar neutral unless otherwise specified.

Practitioner Notes and Drawspace

AFO Height: _____

Standard height is 8" proximal to malleolus

Footplate Length: _____

Left Right

Joint:

Aligner _____

Other: _____

Joint Location:

Lateral- Pronation(PTTD)

Medial- Supination

Bilateral

Footplate Flexibility:

Normal

Stiff

Extra Stiff

Stops*:

Dorsiflexion: _____ Degrees

Plantarflexion: _____ Degrees

Dorsi Assist Bands*:

Color:

Black

Caucasian*

Fabric*: _____

Shipping:

Ground

3-day

2 day

Next day PM

Next Day AM