

Transfemoral Check Socket Work Order

PATIENT

Last name: _____

First Initial: _____

Patient ID: N W

Bilateral Left only Right only

Practitioner: _____ Please change to *your* name if necessary.

Facility: _____

CAD Instructions

Leave as is Ply Adjustment
 Smooth as Needed See Special Instructions

Shape

HiTek Fusion Interface 1.0 - Suction Other
 HiTek Fusion Interface 2.0 - Lanyard

Fab Instructions

Suspension: Lanyard
Distal Adapter: Lanyard Block 3 Prong Suctions 4-hole Rotating
 Pull Valve CTFV Valve Other (Note Part# & Vendor in Special Instructions)

PT Shape Submission

Form Type: Cast Socket to Scan Positive Mold
 Generate from measurements
 Digital (Attach file to online order)

File Name: _____

Date Due: _____ Check Socket 1 2 3

Liner

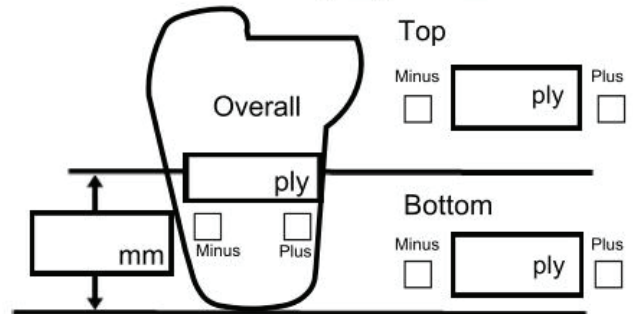
Bock Lite Keasy Liner EVA 35 EVA 45
 Polyethylene BiLam OP Flex (Black) OP Comfort
(Generic for: ProFlex/Northvane) (Generic for: Northvane) (Generic for: ProFlex)
 ProFlex/Silicone OP Flex Comfort None
(Generic for: Northvane white)

Circumferences at:

Measurements:

0 mm	mm
30 mm	mm
60 mm	mm
90 mm	mm
120 mm	mm
150 mm	mm
180 mm	mm
210 mm	mm
240 mm	mm
270 mm	mm
300 mm	mm
Flexion	
Abduction	
Total Length	

Ply Adjustments



SPECIAL INSTRUCTIONS

RUSH Order: