Ideal HealthCare
A MOBILITY CLINIC COMPANY

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Phone: (732) 662-5700 Fax: (732) 662-5699

PROSTHETICS WORK ORDER FORM

PATIENT NAME _____ ID _____

PRACTITIONER _____

DEVICE _____

Supplies	Casting	CLEAR FIT CHECK SOCKET	Delivery	Warranty Work

PATIENT NAME			ID#	
HEIGHT/WEIGHT		IMPACT LEVEL	LOW MOD HIGH	
□ MALE	□ FEMALE	LAMINATION COLOR		

LINER	MANUFACTURER	MODEL	SIZE	
SOCKS				
KNEE				
FOOT				SIDE
				LT RT BL

NOTES:

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APPROVAL DATE (TO BE FILLED OUT BY INS DEPT)		DATE SENT TO LAB	
DEVICE FINISHED AND WORK ORDER RETURNED TO INSURANCE DEPARTMENT (TO BE FILLED OUT BY LAB/PROSTHETIST)			