Ideal HealthCare
A MOBILITY CLINIC COMPANY

(Non)/Therapeutic Foot/Insert Eval/Fit/Delivery Form

Name: _____ Date: _____ DOB: _____ Age: _____ Ht: _____ Wt: _____ Sex: □ M □ F
Date of evaluation: _____ Diagnosis: _____
Services referred for: _____
Describe condition/injury, including onset, surgeries, allergies, deformities, etc.: _____
_____
Describe existing shoe/insert _____

New Shoes: □ N/A Manufacturer: _____ Style/Part #: _____ Size: _____
Style: □ Oxford □ Extra depth □ Other: _____ □ Prefabricated □Custom fabricated
Mold taken: □ No □ Yes/method: □ Digital Scan □ Foam □ Plaster □ Other: _____
Modifications required: □ Velcro closures □ Steel Shank □ Rocker heel/sole □ Other: _____
Clinical rationale for shoe design: _____

New Inserts: □ N/A Manufacturer: _____ Style/Part #: _____ Size: _____
□ Prefabricated Self molding □ Prefabricated heat molded □ Custom Fabricated
Mold taken: □ No □ Yes/method: □ Digital Scan □ Foam □ Plaster □ Other: _____
Describe materials/design to be utilized: _____
_____
Clinical rationale for design: _____

Functional Goals for patient: (check all that are applicable)
□ Protection of foot □ Reduction in pain □ Accommodation to deformity □ Correction of deformity
□ Facilitate healing of injury □ Post surgical support/correction □ Other: _____

Shoe/Inserts to be ordered: □ N/A Estimated date of delivery: _____
X_____
(Only sign above if delivery is other than today's date. At time of final delivery, complete sections below and re-sign w/date of delivery as indicated at bottom)
Patient tolerated procedures without problem: □ Yes □ No (explain): _____

Functional Goals Met: □ Yes □ No (explain): _____
Device checked for structural safety/integrity and compliance with manufacturer guidelines: □ Yes □ No

The patient states satisfaction with the fit and function of shoes/inserts: □ Yes □ No (explain): _____
_____
List additional supplies provided to patient: □ N/A _____
_____

Written and or oral instructions provided to: □ Patient □ Parent □Caregiver
□ Donning/doffing of device □ Skin Inspection □ Care and cleaning □ Usage/break-in period □ Fitting issues
□ Usage to ensure safety □ Patient is an experienced wearer
□ How/whom to report problems related to device/change of physical condition

Patient tolerated the procedure without incident/problem: □ Yes □ No (explain): _____

Follow up scheduled: □ 1 week □ 1-3 weeks □ 1 month □ 3 months □ 6 months □ 1 year □ PRN

Practitioner Signature: _____ Date: _____