

Orthotic Modification Form

CLINIC INFORMATION

Clinic/Clinician Name: _____

Date: _____

Request a Pick Up: YES NO

Preferred Date and Time: _____

PATIENT INFORMATION

Patient Name: _____

Made by Footletic? YES NO

Original ID#: _____

Indicate the modifications you would like us to make.

Top Cover: _____

Bottom Cover:

For Lab Use:

Order ID: _____

Arrival Date: _____