BMI
BERRETTA MEDICAL INC.

V-TEC CUSTOM ORDER FORM

(Cast Mold Required)

PATIENT INFORMATION

Last Name: _____ First Name: _____

Age: _____ Sex: _____ Weight: _____ Height: _____

Occupation: _____ Physical Activities: _____

DIAGNOSIS

Leg: ☐ Right ☐ Left

Instability: ☐ ACL ☐ PCL ☐ MED. COL. (use Acl model) ☐ LAT. COL. (use Acl model) ☐ Medial O.A. (varus condition) ☐ Lateral O.A. (valgus condition)

Date & Type of surgeries (if any): _____

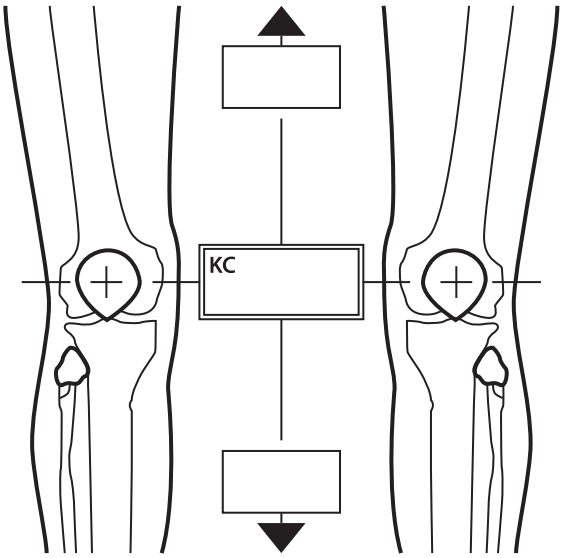
Patient casted by: _____ Phone: _____

BRACE DESIGN

☐ Acl ☐ Sport Cut Top ☐ Sport Cut Bottom ☐ Reinforce Top ☐ Reinforce Bottom

☐ Pcl ☐ Medial OA (Varus Condition) ☐ Lateral OA (Valgus Condition)

Use drawings to indicate special instructions



BRACE LENGTH

Thigh: ☐ 7” ☐ 8” ☐ PCL Strap

Tibia: ☐ 6” ☐ 7” ☐ 8”

Tibia Shell: ☐ Anterior Shell ☐ Posterior Shell

LINER

☐ Evazote ☐ Anti-Migration Neoprene

Extension Stops: _____° Flexion Stops: _____°

(*if no indication, brace will be set at standard 0° extension)

Notes:

COLOR OPTIONS:

Color #: _____ 1. Black 2. Navy Blue 3. Beige 4. Red 5. White 6. Transfer Pattern

BILLING OPTION:

P.O.#: _____ Account #: _____

Bill to: _____

Address: _____

City: _____ Prov./State: _____

Zip.: _____ Country: _____

SHIPPING INSTRUCTIONS:

Ship to: _____

Address: _____

City: _____ Prov./State: _____

Zip.: _____ Country: _____

Shipping: ☐ Standard ☐ Expedited ☐ Next Day

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