

V-TEC CUSTOM ORDER FORM

PATIENT INFORMATION

Last Name: _____ First Name: _____

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

Occupation: _____ Physical Activities: _____

DIAGNOSIS

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

Date & Type of surgeries (if any): _____

Patient casted by: _____ Phone: _____

BRACE DESIGN

Acl Sport Cut Top Reinforce Top
 Pcl Sport Cut Bottom Reinforce Bottom
 Medial OA (Varus Condition) Lateral OA (Valgus Condition)

BRACE LENGTH

Thigh: 7" 8" PCL Strap
Tibia: 6" 7" 8"
Tibia Shell: Anterior Shell Posterior Shell

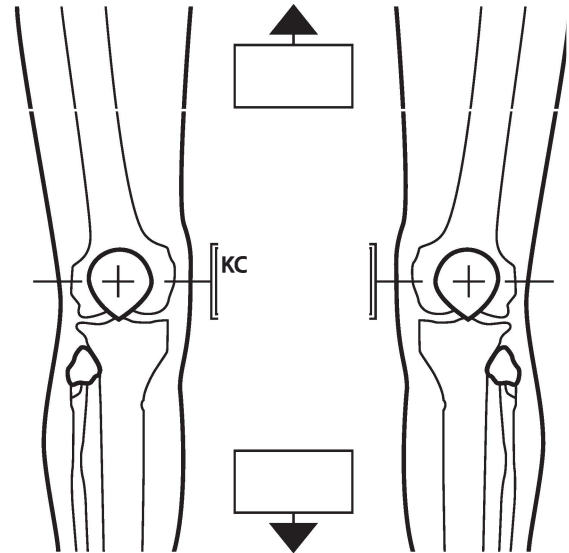
LINER

Evazote Anti-Migration Neoprene

Extension Stops: _____ ° Flexion Stops: _____ °
(*if no indication, brace will be set at standard 0° extension)

Notes:

Use drawings to indicate special instructions



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: Ground Express

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