

Trilateral Orthosis

Practitioner _____ Branch Name _____
 PO# _____ Date: _____ Ship Via: _____
 Address _____
 City _____ State _____ Zip _____

Fillauer LLC
 Tel: 800.251.6398
 Fax: 423.698.6076

Hosmer
 Tel: 800.827.0070
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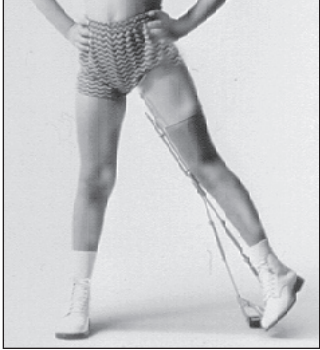
Patient Information

Patient's Name _____
 Age _____ Sex _____ Weight _____ Height _____
 Shoe Size _____
 Ship To Address _____

Measurements

Remarks _____

Options



Prefabricated Ischial Weight Bearing
 Thigh Cuffs are supplied in the
 following sizes:

- | | |
|---------------------------------|-----------------------------|
| <input type="checkbox"/> 10-1/2 | <input type="checkbox"/> 11 |
| <input type="checkbox"/> 11-1/2 | <input type="checkbox"/> 12 |
| <input type="checkbox"/> 12-1/2 | <input type="checkbox"/> 13 |
| <input type="checkbox"/> 13-1/2 | <input type="checkbox"/> 14 |
| <input type="checkbox"/> 14-1/2 | <input type="checkbox"/> 15 |
| <input type="checkbox"/> 15-1/2 | <input type="checkbox"/> 16 |
| <input type="checkbox"/> 16-1/2 | <input type="checkbox"/> 17 |

In the event a plaster cast is required,
 it should be taken in 30° abduction
 and should extend from mid thigh
 to crest of ilium and include the
 buttock on the affected side only.

Shoe elevation on sound side is not
 normally used.