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SANDAL WORK ORDER

Doctor's Name _____ Account # _____ Date _____

Address _____ State _____ Zip _____

Phone () _____ Fax () _____

Patient's Last Name _____ First Name _____

Age _____ Sex _____ Weight _____ Height _____ Shoe Size _____

Shoe Type _____ Heel Height _____

Diagnosis _____ Date Required (\$25 overnight shipping may apply) _____

Image CUSTOM ORTHOTIC SANDAL

2 STRAP

Smooth

Suede

Velcro

Color _____

Shoe Size _____

3 STRAP

Smooth

Suede

Velcro

Color _____

Shoe Size _____

CLOG

Smooth

Suede

Velcro

Color _____

Shoe Size _____

THONG

Smooth

Suede

Color _____

Shoe Size _____

DREW SANDALS

Style _____

Color _____

Shoe Size _____

Width _____

BITE SANDALS

Style _____

Color _____

Shoe Size _____

Width _____

BIRKENSTOCK

Style _____

Color _____

Shoe Size _____

Width _____

ADDITIONS/ACCOMODATIONS

Extra Padding

Heel Pad

Met Head Accom

Rocker Bottom

Plastizote Top Cover

Lateral Wedges

Heel Lift L R

Other

Heel Spur Accom

Met Pads

Line Straps with

Ultrasuede

SPECIAL INSTRUCTIONS/DIAGNOSIS

