



Please put fax number on all orders

ORDER FORM



BILL TO:

SHIP TO:

Contact Name: _____

Phone: _____ Fax: _____

PO NUMBER: _____

Email address: _____

MRL Use Only **Confirmation Number #** _____ **Gender** _____
 Size _____ **Style** _____

(Please Print) Patient Name: _____ **Male** **Female**

Left Foot

Right Foot

Length: _____

Length: _____

Shoe Size Needed: _____

Width: _____

Width: _____

Orthotic Inserts: _____

(3 Pair of inserts will be sent unless specified here!)

(check below if either condition applies)

Brannock:

Brannock:

Heel to Ball Length: _____

Heel to Ball Length: _____

Thick/Fleshy Foot _____ **High Instep** _____

Stride Lite Lycra

Black Velcro Strap 100-01

Black Velcro Lace 101-01

Taupe Velcro Strap 100-03

Stride Lite Boot

Black General 451-02

Stride Lite Leather

Black Velcro strap 400-01

Black Velcro Lace 410-01

Brown Velcro Strap 700-02

Taupe Velcro Strap 600-03

Taupe Velcro Lace 601-03

Stride Lite Leisure

Black Lace 1101-01

Stride Lite Sport

White Velcro 900-00

White Lace 901-00

Black Velcro 800-01

Black Lace 801-01

Mesh 1637-04

Stride Lite Daisy

Black 1000-01

White 1000-00

Stride Lite Breeze

Black Velcro 1279-01

Brown Velcro 1279-02

Bone Velcro 1279-03

Stride Lite Mohican

Black Leather 1664-01

New!

Stride Lite Buckeye

Black Velcro 1282-01

Two-Tone Velcro 1282-12

Measured By: _____

Time Measured: _____

I have been accurately measured for the therapeutic shoes and insoles. I will contact my fitter with any changes in my feet including discoloration or discomfort of any kind, once I have taken my shoes home.

Patient's Signature: _____ Date: _____

MEDICAL RESOURCES LIMITED INC. 1-800-998-4199 OR FAX 1-800-997-9980