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**WAMHOFF
MOBILITY LAB**

Patient Name: _____

Side: _____ Height: _____ Weight: _____

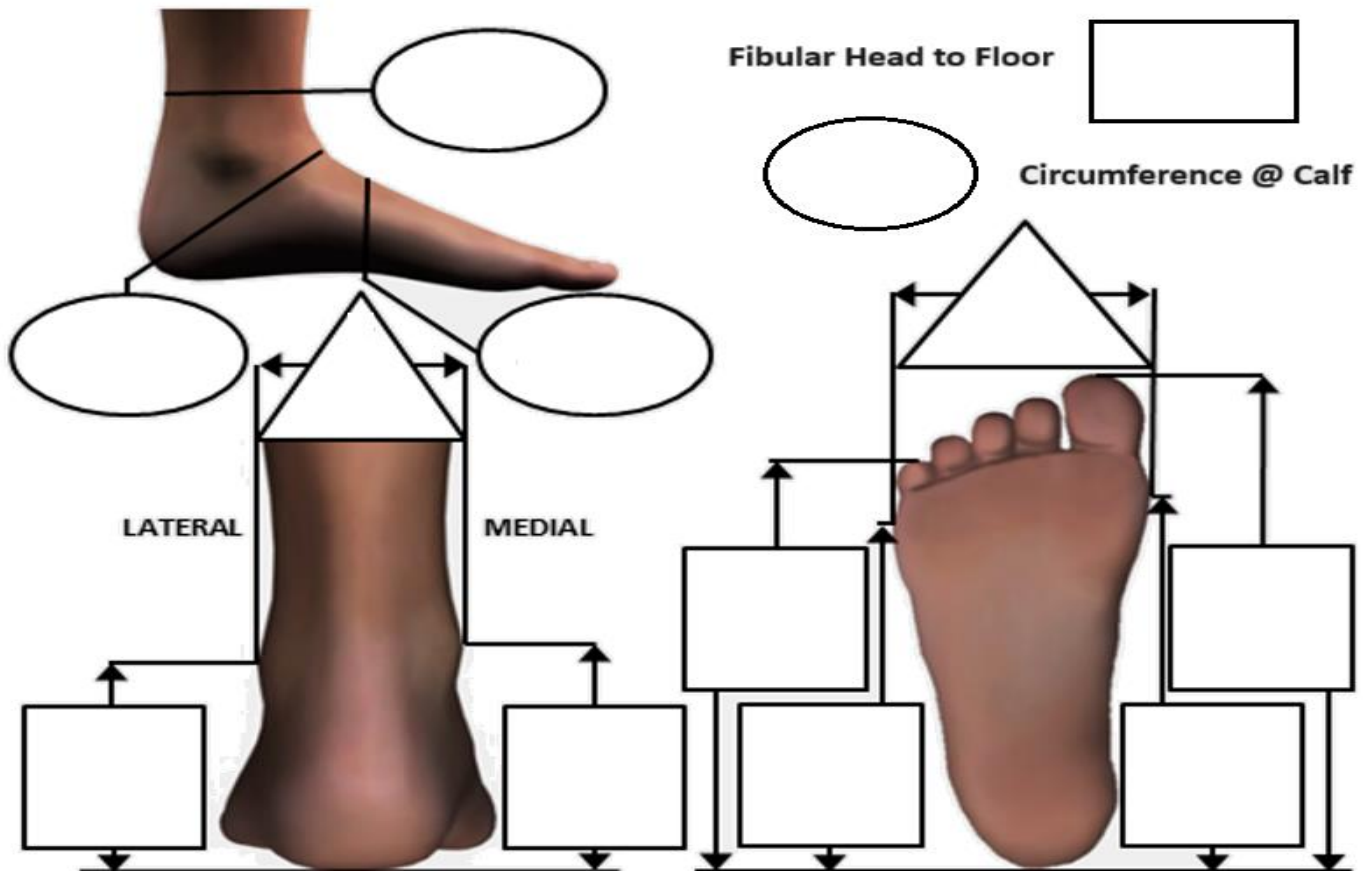
Age: _____ Sex: _____ Diagnosis: _____

Practitioner: _____ Facility & Location: _____

Phone/Email: _____ Ship to Address: _____

Date Ordered: _____ Requested Date Needed: _____ PO#: _____

Measurements



CROW Specifications

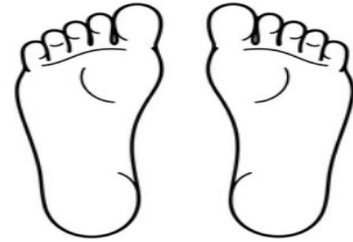
Model Type: _____ **CROW Style:** _____

Alignment: Leave Cast as is Correct cast to neutral Correct cast to specified angles below:

Sagittal: _____° Plantarflexion / Dorsiflexion Hindfoot: _____° Inversion / Eversion

Forefoot: _____° Inversion / Eversion Heel height: _____ Tibial Inclination Angle: _____°

Ulcer Location and Modification Notes:



Shell Options

Posterior Shell Plastic: _____ **Posterior Shell Padding:** _____

Anterior Shell Plastic: _____ **Anterior Shell Padding:** _____

Plastic Color: _____

Rocker Options

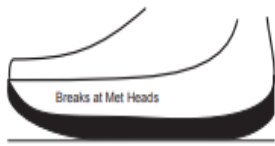
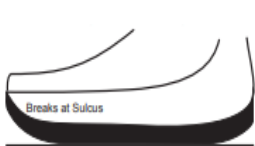
Sulcus Rocker

Metatarsal Rocker

Mid-Stance Rocker

Full Rocker

Alternate Rocker



Additions:

Reinforcement: _____ **Toe Filler:** _____

Finishing:

CROW Height: _____ **Shoe Size:** _____ **Soling:** _____

Strapping:

Straps Color: _____ **Material:** _____ **Pattern:** _____ **Closure:** _____

Notes: