RETURN FORM

Request Date ______________________ Patient Name ______________________

Practitioner ______________________ Patient ID ______________________

Office/Group Name ______________________ Original Order # -from shell-required) ______________________

Please describe the reason for the return/additional instructions:

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☐ Do as I instruct ☐ I need a phone consultation

ADD/CHANGE SHELL MODIFICATIONS
(circle one)

Narrow heel ______mm/in L R B/L

Widen heel ______mm/in L R B/L

Raise Arch ______mm/in L R B/L

Lower Arch ______mm/in L R B/L

Shorten shell______mm/in L R B/L

Lengthen shell ______mm/in L R B/L

ADD/CHANGE PADDING
(circle one)

Met Pads _____1/16 ____ 1/8 L R B/L

Neuroma Pad Innerspace L R B/L
1 2 3 4

Heel Cushion _____1/16 _____ 1/8 L R B/L

Heel Spur Pad _____1/16 ____ 1/8 L R B/L

REARFOOT POST

Remove Add Change (Circle one) L R B/L (Circle one)

______Degree Varus/Valgus (Circle one)

CHANGE COVER MATERIALS

EVA 35 (Black) _____1/8 _____1/16

Micro-suede (Black) _____1/8 _____1/16

Neolon (Black) _____1/8 _____1/16

Plastazote (Black) _____1/8

Black vinyl w/Poly-U _____1/8 _____1/16

Ucolite (Black Perforated) _____1/8 _____1/16

Add Poly-U Midlayer _____1/8 _____1/16

CHANGE COVER LENGTH/WIDTH

Change top cover length Met Sulcus Toes (Circle one)

Increase top cover length ______mm/in

Increase top cover width ______mm/in

Other Instructions:

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Ship all returns to:
Attn: Arize Shipping Department
4824 SW 75th Ave
Miami, FL 33155

Rev: 3, Jan 2024