

Ordered by: _____ Phone # (_____) _____

BILLING: P.O. Number _____ Townsend Account # _____

Bill To: _____

Ship To: _____

Address: _____

Address: _____

City: _____

City: _____

State: _____ Zip Code: _____ Country: _____

State: _____ Zip Code: _____ Country: _____

Phone: (_____) _____ Fax: (_____) _____

Phone: (_____) _____ Fax: (_____) _____

Shipping Preference: Ground 2-Day P.M. 2-Day A.M. Next Day P.M. Next Day A.M.
 (If no preference is indicated, this order will be shipped 2 Day P.M.) Note: We do not ship products directly to patients.

Patient's Last Name: _____

Patient's First Name: _____

Male Female Age _____ Height _____ Weight _____

Leg Left Right

Ligament: ACL PCL LCL MCL

Meniscus Damage: Medial Lateral

Surgeries (type/date): _____

Model

ACL Combined Instabilities (choose strap or band)
 PCL Strap* PCL Rigid Band*




Thigh Shell Length

7 Inch 8 Inch

Tibia Shell Length

6 Inch 7 Inch 8 Inch

Tibia

C: Anterior Single Band 
 D: Posterior Single Band 
 E: Double Band* (7" or 8" only) 
 Single Strut KAFO (must complete additional form for brace extension)

Hinges

TM5+ Hinges -- Includes extension stop kit
 Optional flexion stop kit*
 Add optional extension assist bands/posts*

Hinge Material

6061 Aluminum (standard, if no hinge material is indicated)
 Stainless Steel*

Finish and Color

Textured Powdercoat Finish

Black Antique Pewter Royal Blue Burgundy

High Gloss Paint Finish

Black Royal Blue Burnt Orange Dark Violet
 Emerald Green Steel Blue Quicksilver
 Indy Yellow Burgundy White Beige

Custom Paint Finish* -- Indicate Custom Paint # _____

Custom Hydro Dip Finish* Provide Hydro Film # _____

Options

C/S Package* (for dynamic compression and enhanced suspension)
 No wraparound attachment of Synergistic Suspension Strap
 (recommended if patient has a prominent fibular head)

Spoooner Patella Stabilizing Attachment*

Brace Cover*

Posterior Closure
 Pull On

Undersleeves*

18" Cotton 18" Neoprene 22" Neoprene

Thigh Sleeves*

1/8 Atrophy Thigh Sleeve 1/16 Comfort Thigh Sleeve

M-L measurement at knee center _____

Special Instructions: _____

Please complete and fax this form to 800.798.2722 (24-hours a day). If you are calling in your order, this form indicates the options and information that will be required by our staff. For phone orders, please call 800.700.2722 between 6:00 a.m. and 4:00 p.m. (PST).

* Indicates additional charges apply