Upper Extremity Order Form

EMAIL TO: ORDERS@GPFINC.COM OR FAX: 727-842-2264

NAME OF PATIENT: _____ *CONTACT PHONE:* _____

PO #: _____ *TODAY'S DATE:* _____ REQUESTED BY DATE: _____

CLINIC NAME: _____ *PRACTIONER'S NAME:* _____

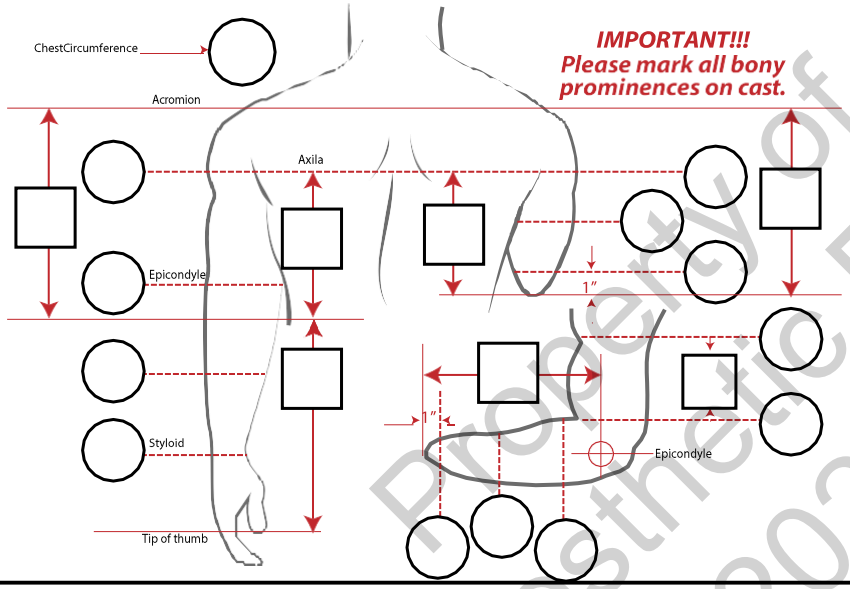
SHIP TO ADDRESS: _____ *CITY:* _____ *STATE:* _____ *ZIP:* _____

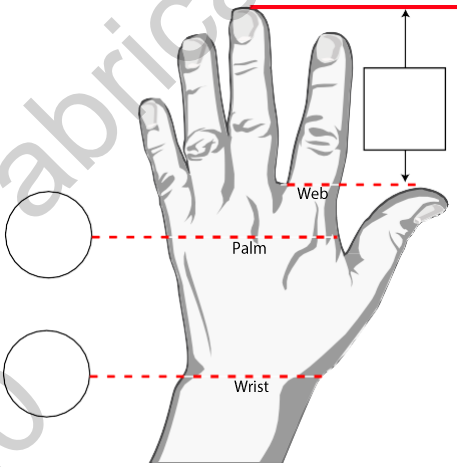
SHIP VIA UPS: GROUND / 3DAY / 2DAYAM / 2ND DAY / NEXT DAY / NDS / NDAM *SHIPPER ID:* _____

PATIENT AGE: _____ M / F HEIGHT: _____ WT: _____

PROSTHESIS TYPE: _____ LEFT / RIGHT

ACTIVITY LEVEL: 1 2 3 4





PLEASE CLEARLYY MARK YOUR SELECTIONS

Length Axilla to Epicondyle: _____**inches**

Length Epicondyle to End of Wrist:_____**inches**

Length Cable to Hook Adaptor:_____**inches**

SPECIAL FEATURES/ NOTES:_____

_____

Standard Weight / Heavy Duty **Size of Hand** _____ **Cosmetic Glove** _____

Color # _____

Limb Color: Caucasian / Lt Brown / Med Brown / Dark Brown

ADDITIONAL INSTRUCTIONS: _____

_____

_____

_____

_____

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