



Patient Name _____

Comments/special requirements:

Clinic Name _____

Hospital Name _____

Measured by _____ Date _____

Repeat Garment No. _____

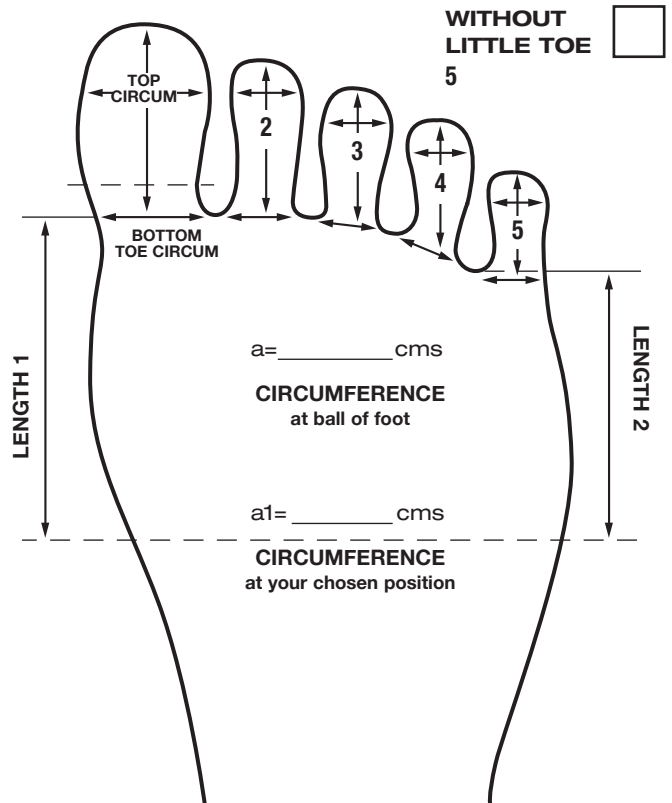
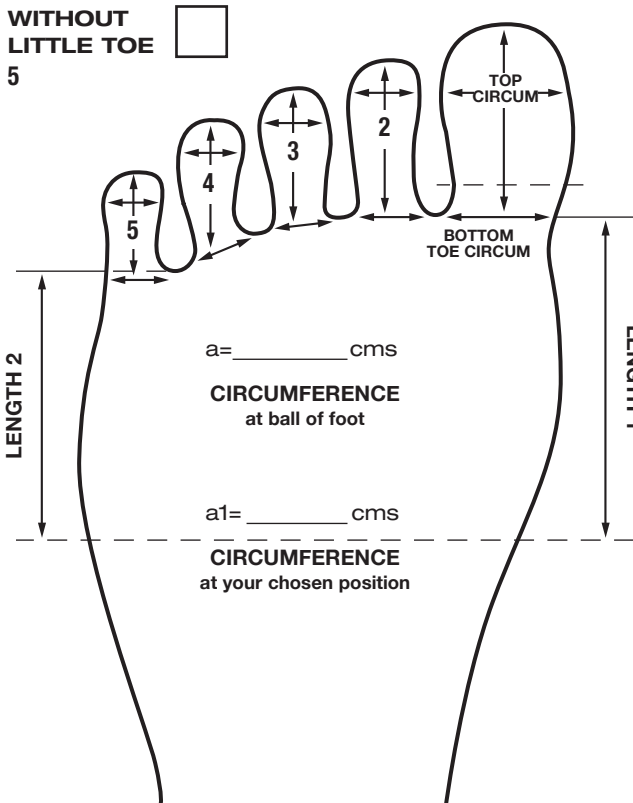
TOE CAPS

Please select choice of material: Pertex Light CCL1 Pertex 2 CCL2 Pertex 3 CCL3 Goldpunkt 2 CCL2 Goldpunkt 3 CCL3 MicroFine 20-36 mmHg

CIRCUMFERENCE	TOE	TOE 5	TOE 4	TOE 3	TOE 2	TOE 1	TOE	TOE 1	TOE 2	TOE 3	TOE 4	TOE 5	CIRCUMFERENCE
	TOP CIRCUM						TOP CIRCUM						
	BOTTOM CIRCUM						BOTTOM CIRCUM						
	TOE LENGTH						TOE LENGTH						

LEFT

RIGHT



QUANTITY COLOUR

QUANTITY COLOUR

OPEN TOE CLOSED TOE

OPEN TOE CLOSED TOE

FOOT LEFT	
LENGTH 1:	_____ cms
LENGTH 2:	_____ cms

FOOT RIGHT	
LENGTH 1:	_____ cms
LENGTH 2:	_____ cms

MEASUREMENTS IN CMS PLEASE USE BLACK INK

