

Cervical Order Form

OWNER INFORMATION			
Owner Name:			
Ph:	Cell:	Email:	
Address:			
City:	State:	ZIP:	
VETERINARIAN			
Vet Name:			
Ph:	Email:		
Vet Clinic:			
Address:			
City:	State:	ZIP:	
BILLING (CHECK ONE)			
<input type="checkbox"/>	BILL VET CLINIC (USE BILLING ADDRESS ABOVE)		
<input type="checkbox"/>	BILL OWNER (USE BILLING ADDRESS ABOVE)		
<input type="checkbox"/>	OTHER:	NAME:	
Ph:	Email:		
Address:			
City:	State:	ZIP:	
PATIENT			
Patient name:			
Breed:			
Age:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Weight (lbs or kgs):
Activity Level (ie. Low, moderate, high):			
Surgery (type and date)?			
Diagnosis:			
CAST			
PLEASE REVIEW CASTING INSTRUCTIONS AND VIDEOS PRIOR TO CASTING			
<small>Patient cast position is critical in proper fabrication and fit of a brace or prosthetic. The device is fabricated directly from the cast. A standing digitigrade position is optimal positioning. A new cast may be required if cast or position is not proper or correctable.</small>			
Casting position:	<input type="checkbox"/> Standing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Sedated <input type="checkbox"/> Laying
Pics included?	yes	no	Email to paws@kineticpaws.com
Please indicate if any possible casting corrections may be required?			yes <input type="checkbox"/> no <input type="checkbox"/>
If yes, please explain:			

Measurements	
Inches or Centimeters?	
Cervical	
Thoracic	

Veterinarian Signature: