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Stamp

Date:..... Patient's Name:.....

Customer:..... Signature:.....

LEFT CIRCUMFERENCES AND LENGTHS

V° IV° III° II° I°

ℓ XZ

cZ

cX

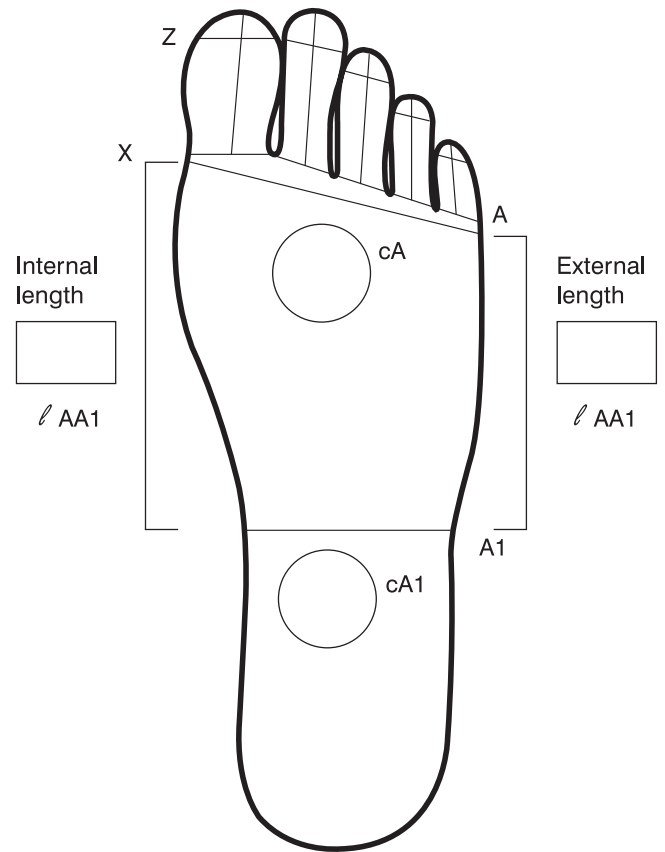
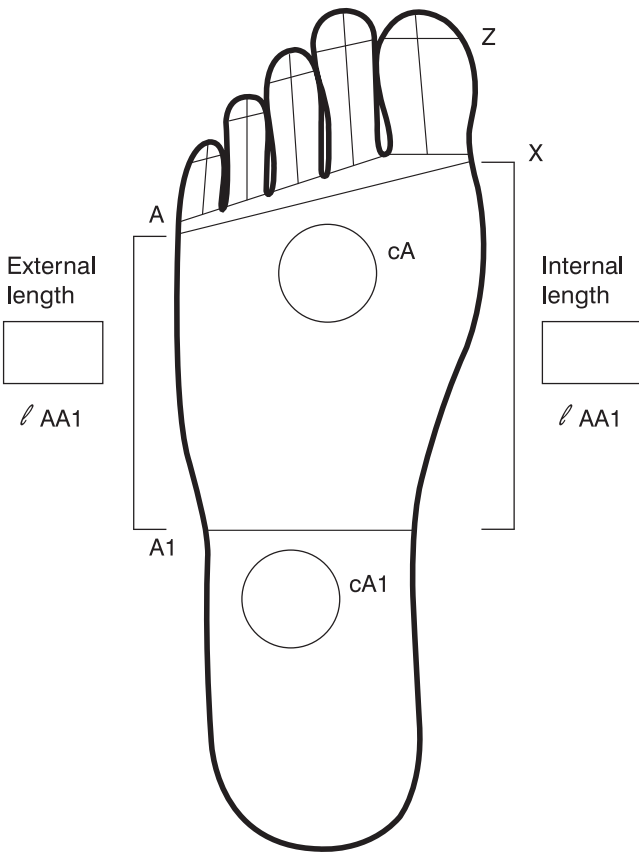
RIGHT CIRCUMFERENCES AND LENGTHS

I° II° III° IV° V°

ℓ XZ

cZ

cX



COMPRESSION	COLOUR	QUANTITY	OPTIONS	
Ccl 1 <input type="checkbox"/> 2 <input type="checkbox"/> Foot cap	<input type="checkbox"/> Beige	<input type="checkbox"/> Left _____ <input type="checkbox"/> Right _____	LEFT	RIGHT
			<input type="checkbox"/> 4 Toes <input type="checkbox"/> 5 Toes	<input type="checkbox"/> 4 Toes <input type="checkbox"/> 5 Toes

SPECIAL REQUEST

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