



CARPAL SUPPORT ORDER FORM

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Clinic Name: _____

Attn: _____

Address: _____

City: _____ **State:** _____ **Zip/Postal Code:** _____

Country: _____

Phone number: _____

E-mail: (for order confirmation) _____

Name on Credit Card: _____

Mailing Address for Credit Card Statement: _____

City: _____ **State:** _____ **Zip/Postal Code:** _____

Country: _____

Phone number: _____

Credit Card # ____ **Owners:** ____ **Clinic:** _____ **Exp Date:** ____ **CVV:** ____

Signature: _____

Pet's Name (first and last): _____

Pet's Breed: _____ **Age:** _____ **Weight:** _____

Diagnosis: _____

PET'S HEALTH: _____ Cushing's Disease _____ Addison's Disease

_____ Compromised Auto-Immune System _____ Severe skin allergies _____ Long-term Prednisone Therapy

MEASUREMENTS & CASTINGS: *To be taken with patient weight bearing. CASTING must be made with patient weight bearing or casting adapted to the weight bearing desired angle of limb.*

2 layers of Soft Plast Casting tape wrapped around the limb extending well above the desired height of the product and including toes. .

MEASUREMENTS (print clearly) _____ **Centimeters** _____ **Inches**

LEFT _____ **RIGHT** _____

Standard Carpal Support: *Yes to any of the above health conditions will require a lined support. Deformities or abnormalities may require casting and custom support.*

Dew Claw: **YES** _____ **NO** _____

- 1.) _____ Measure around leg at middle of carpus.
- 2.) _____ Measure from middle of carpus to top of paw
- 3.) _____ Measure from middle of carpus to point of elbow
- *4.) _____ If taller device is desired, measure from mid carpus to top of desired support
- *5.) _____ Measure around leg at top of support (for taller support only)

Extra Stabilization Straps for increased support **YES** _____ **NO** _____

Carpal Support will be used with External Splinting **YES** _____ **NO** _____

NOTES: