



FOOT MODULE			
PRODUCT	ID	SIZE	CATEGORY
HiPro	HIP	22-29	1-9*
ROGUE 2	ROG2		
RAMPAGE	RAM		
RAMPAGE LP	RAMLP		
HiPro EVAQ8	EVQH		
ROGUE 2 EVAQ8	EVQR2		
RAMPAGE EVAQ8	EVRAM		
RAMPAGE LP EVAQ8	EVRAMLP		
HiPro H2O	H2H		
ROGUE 2 H2O	H2R2		
RAMPAGE H2O	H2RAM		
RAMPAGE LP H2O	H2RAMLP		
ROVER	ROV	22-30	0-9*
Chopart	CHO		
Kid	KID	19-21	1P-8P*

*Category selections vary with sizes. Please refer to category selections available for each product.

NOTE: Increasing category numbers indicate increased keel response.
FOR BILATERAL PATIENTS: Increase by one category for added stability.

FOOT SHELL				
PRODUCT	ID	SIZE	SIDE	COLOR
HiPro	FS	22-29	L: Left R: Right	1: Light 3: Dark
ROGUE 2				
RAMPAGE				
RAMPAGE LP				
HiPro EVAQ8				
ROGUE 2 EVAQ8				
RAMPAGE EVAQ8				
RAMPAGE LP EVAQ8				
Chopart	FSK	22-30		
ROVER				
Kid		19-21		

FOOT MODULE		
ID	SIZE	CATEGORY

EVAQ8 ORDERS:

Patient wears a seal-in-liner:

☐ Yes ☒ No

NOTE: Black Spectra Sock and Heel Wedge included in each Foot Module delivery (excluding H2O Models).

FOOT SHELL			
ID	SIZE	SIDE	COLOR

FOOT SHELLS ARE NOT INCLUDED WITH FOOT MODULES AND MUST BE ORDERED SEPARATELY.

NOTE: If Warranty or 60-Day Return Re-Order, please call Customer Service prior to ordering.

ORDER DATE: _____ REQ SHIP DATE: _____ NEED BY DATE: _____

SHIP VIA: ☐ Ground ☐ 2-Day ☐ Next Day ☐ Early AM

PROSTHETIST NAME: _____ P.O. #: _____

FOOT BRAND AND MODEL BEING REPLACED: _____

SPECIAL ORDER NOTES: _____

BILL TO

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

EMAIL*: _____

SHIP TO (SAME AS BILLING ADDRESS) ☐

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

EMAIL: _____

(*REQUIRED FOR SHIPPING CONFIRMATION)

PATIENT DATA *(Section does not need to be filled out if patient data is listed on the P.O.):*

NAME/ID#: _____ AGE: _____ GENDER: ☒ M ☐ F

FOOT SIZE (cm): _____ WEIGHT (lbs): _____ HEIGHT: _____ ft _____ in

AMPUTATION: ☐ Left ☐ Right ☐ Bilateral MODULE: ☐ Left ☐ Right ☐ Both

LEVEL: ☐ Transtibial-BK ☐ Transfemoral-AK ☐ Hip Disartic-HD ☐ Knee Disartic-KD ☐ Symes

ACTIVITY LEVEL: ☐ Low (walking, golfing) ☐ Medium (hiking, skiing) ☐ High (basketball, wakeboarding)
☐ High-Impact (sprinting, basketball)

CLEARANCE MEASUREMENT (in): _____

(From most distal aspect of socket to the ground. Include space for a liner, shuttle lock, etc.)

PATIENT NOTES: _____

RETURNS, ADJUSTMENTS, CREDITS

We are committed to the complete satisfaction of the prosthetist and amputee. We deliver most products with a 60-day "Satisfaction Guarantee." If you are dissatisfied with a PROTEOR USA standard production product for any reason, you may return it for a full refund within 60 days of the original invoice date. Modular components and liners can be returned within 60 days of purchase only if their packaging is unopened. All returns require a Return Authorization Number (RA#), which is obtained by calling PROTEOR USA Customer Service or the Distributor through which the product was originally ordered. No returns will be accepted without an RA#.

A restocking fee of 20% may be applied to orders returned after the 60-day Satisfaction Guarantee.

INTERNAL USE

CS Rep: _____ Date: _____ Order #: _____



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