



# Custom Lower Extremity Order and Measuring Form

Custom products have an estimated lead time of 10-14 business days  
 The ReidSleeve® Products are available for the upper and lower extremities. FDA Class 1. CFR 880.5160.

**Check all products for this order:**  
 (◆Material colors are subject to change without notice)

- |                                                        |                                                      |                                                                  |
|--------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Classic ReidSleeve® w/ Gauge  | <input type="checkbox"/> Precise Gauge (stand alone) | <input type="checkbox"/> PowerSleeves®◆ (stand alone) Qty: _____ |
| <input type="checkbox"/> Classic ReidSleeve® w/o Gauge | <input type="checkbox"/> TheCinch®                   | <input type="checkbox"/> OptiFlow® SC◆ w/ _____ PowerSleeve(s)   |
| <input type="checkbox"/> Carry Case (single)           | <input type="checkbox"/> OptiFlow® EC                | <input type="checkbox"/> Comfort Sleeve◆ w/ _____ PowerSleeve(s) |
| <input type="checkbox"/> Carry Case (bilateral)        |                                                      | <input type="checkbox"/> The Jazz w/ _____ PowerSleeve(s)        |

	<b>Fill in all circumferences:</b>	<b>Fill in all lengths:</b>	<b>Custom options – Universal:</b>
	g _____ Thigh f _____ Mid-Thigh e _____ Knee d _____ Below Knee c _____ Calf b _____ Ankle y _____ Instep a _____ Toe	z-h _____ Heel to Groin (Full Leg) z-f _____ Heel to Mid-Thigh (¾ Leg) z-e _____ Heel to Knee z-d _____ Heel to Below Knee (½ leg) z-c _____ Heel to Calf z-b _____ Heel to Ankle z-x _____ Foot Length	<input type="checkbox"/> Hip/Knee Extension <input type="checkbox"/> No Foot
	<b>Measuring for:</b> <input type="checkbox"/> Left Side <input type="checkbox"/> Full Leg <input type="checkbox"/> Right Side <input type="checkbox"/> ¾ Leg <input type="checkbox"/> ½ leg	b-h _____ Ankle to Groin b-e _____ Ankle to Knee b-c _____ Ankle to Calf	<b>Custom options - Classic only:</b> <input type="checkbox"/> Groin cut-out <input type="checkbox"/> Zipper (½ leg only) <input type="checkbox"/> Asymmetrical (Use Asymmetrical/Lipoma form) <input type="checkbox"/> Lipoma (Use Asymmetrical/Lipoma form) <input type="checkbox"/> D-Ring
	<b>Measuring in:</b> <input type="checkbox"/> Inches <input type="checkbox"/> Centimeters	<b>Custom Colors – Classic Only:</b> Shell#: _____ Accent: _____ Liner#: _____	<b>Custom Colors – Jazz Only:</b> Liner#: _____ PowerSleeve#: _____  <small>(■ Default color is black)</small>

### Patient Information

Name or Order# \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 I authorize release of my name to Peninsula Medical Inc. for identification purposes related to the manufacturing of my custom garment.  
 Signature (patient) \_\_\_\_\_ Date \_\_\_\_\_

### For Peninsula Medical Use Only

Finished goods inspected for quality compliance to above specifications:

By \_\_\_\_\_ Date \_\_\_\_\_

### Bill To

PO Number \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_

### Ship To

(if different than billing info)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone \_\_\_\_\_

### Method Of Shipping

- Ground     3<sup>rd</sup> Day     2<sup>nd</sup> Day     Overnight  
(Default method is 3rd day or ground if on west coast)  
 Other \_\_\_\_\_

### Date Need Shipment Delivered\*

\*Peninsula Medical, Inc. reserves the right to change shipping method if deemed necessary to accommodate a specific delivery date. Expedited orders will incur a 10% fee.

I understand that this is a custom made garment and the garment will be made to the measurements specified above. Peninsula Medical, Inc. is not responsible for measuring errors. Should the garment need to be returned for alterations due to measurement errors, the fee for alterations are the responsibility of the undersigned.

Signature (guarantor of measurements) \_\_\_\_\_ Date \_\_\_\_\_

If credit terms have been provided, I agree to pay the total amount on the invoice within the terms on file with Peninsula Medical, Inc. All invoices are **due and payable within 30 days or per terms of written agreement** of the date listed on the invoice. Any invoice over 30 days or the written terms on file is considered delinquent and a **1.5% late fee** will be assessed monthly. Should any invoice become delinquent I understand the account may be placed on a C.O.D. basis, a prepay basis or the account may be suspended.

Signature (purchaser) \_\_\_\_\_ Date \_\_\_\_\_