Foot Solutions of Reading
654 B Philadelphia Ave
Shillington, PA 19607
Phone: 610-775-4950
Fax: 610-775-4951
Reading@footsolutions.com

Standard Written Order (Prescription)

Order valid for only 6 months from date of signature

PATIENT NAME_____DOB_____

PHYSICIAN (PRINT) _____**DATE OF ORDER**_____

I AM PRESCRIBING

☐ 1 Pair A5500 Depth Inlay Shoes

☐ 3 Pairs A5512 Heat Molded Multi-Density Inserts ☐ 3 Pairs A5513/A5514 Custom Fabricated Inserts

☐ Partial Foot Toe Filler ☐ Right ☐ Left ☐ 3 Custom Inserts Other Foot

☐ Other (Describe)_____

I certify that I am the prescribing physician. I have reviewed this Detailed Written Order and confirm the items prescribed and diagnosis are to the best of my knowledge accurate.

Physician Signature_____**Date**_____

NPI_____**Phone**_____**Fax**_____

Please Fax to: 610-775-4951