Goal Pediatric Orthotics

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Patient Name: _____ **DOB:** _____ **Date:**_____

Diagnosis (ICD-10's): _____

Suggested Orthotic Intervention:

☐ Custom: _____

☐ Custom: _____

☐ Other: _____

☐ Other: _____

OR

☐ Custom Orthotics (codes listed below)

_____

_____

_____

_____

Frequency/duration: _____

☐ I agree with the above treatment plan

Physician Signature:_____ **Date**: _____

Printed Physician Name:_____ **NPI**: _____

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