BK MEASUREMENT FORM

Company Name: _____ Due Date: _____

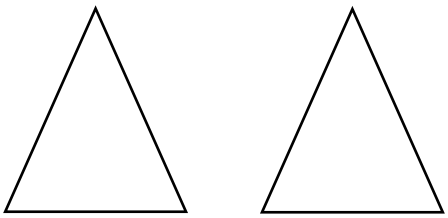
Patient Name: _____ PO# _____

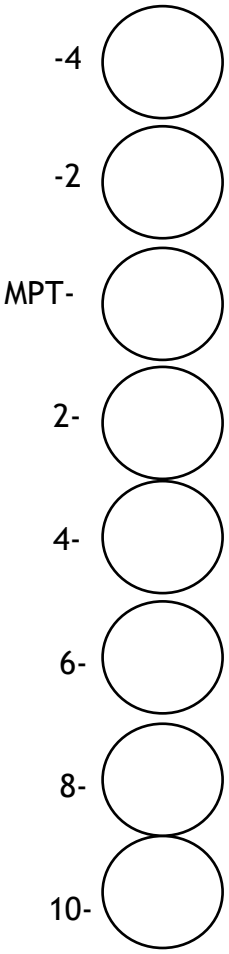
RIGHT____ / LEFT____ CARVING ____ CHECK SOCKET____ ORFITRANS STIFF SOCKET____

POLYPROPYLENE SOCKET ____ LAMINATION/COLOR ____/_____

MPT ⟶ DISTAL END







FABRICATION NOTES: _____

_____

_____

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