

RUSH FOOT® ORDER GUIDE AND FORM

FOOT MODULE GUIDE				
PRODUCT	ID	SIZE	CATEGORY	TOE CONFIGURATION
ROGUE 2	ROG2	22-29	1-9*	RU: Regular Universal SR: Sandal Right SL: Sandal Left
ROGUE 2 EVAQ8	EVQR2			
HiPro	HIP			
RAMPAGE	RAM			
RAMPAGE LP	RAMLP			
HiPro EVAQ8	EVQH			
RAMPAGE EVAQ8	EVRAM			
RAMPAGE LP EVAQ8	EVQRAML			
ROGUE 2 H2O	H2R2			
HiPro H2O	H2H			
RAMPAGE H2O	H2RAM			
RAMPAGE LP H2O	H2RAMLP			
ROVER	ROV	22-30	0-9*	RU: Regular Universal
Chopart	CHO	19-30		
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.

STANDARD FOOT SHELL GUIDE (RU) with CAP				
PRODUCT	ID	SIZE	SIDE	SKIN TONE
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		19-21		
Kid				

SANDAL TOE FOOT SHELL GUIDE (SR/SL) NO CAP			
(ROGUE 2, HiPro, RAMPAGE, RAMPAGE LP, and EVAQ8 Models Only)			
ID	SIZE	SKIN TONE	TOE CONFIGURATION
FTC-4R	22-29	L4: Light M4: Medium D4: Dark	SR: Sandal Right SL: Sandal Left

FOOT MODULE ORDER			
ID	SIZE	CATEGORY	TOE

EVAQ8 ORDERS:

Patient wears a seal-in-liner:

☐ Yes ☐ No

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



Foot Shells are **not** included with foot modules and must be ordered separately.

STANDARD FOOT SHELL ORDER (RU)			
ID	SIZE	SIDE	SKIN TONE



SANDAL TOE FOOT SHELL ORDER (SR/SL) (NO CAP)			
(ROGUE 2, HiPro, RAMPAGE, RAMPAGE LP, and EVAQ8 Models Only)			
ID	SIZE	SKIN TONE	TOE
FTC-4R-1			

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

IMPACT LEVELS: ☐ Low (Walking, Golfing) ☐ Moderate (Jogging, Hiking) ☐ High (Running, 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 #: _____



MELBOURNE
26-32 Clayton Road
Clayton VIC 3168

SYDNEY
3/55-57 Newton Road
Wetherill Park NSW 2164

ADELAIDE
31 Dunorlan Road
Edwardstown SA 5039

CONTACT US
1300 672 937
sales@opchealth.com.au