5-90 Lancing Drive, Hamilton, ON L8W 3A1
1-888-444-3032
Fax: 289-799-7474
Email: info@oolab.com

OOLAB OUTGROWTH PROGRAM REQUEST

DR/CLINIC INFORMATION

NAME:

ADDRESS

PHONE:

FAX:

EMAIL:

PLEASE PRINT

PATIENT INFORMATION

NAME:

❑ M ❑ F OTHER SHOE SIZE:

WEIGHT:

DATE OF BIRTH: AGE:

The OOLab Outgrowth Program helps to accommodate growth related replacement pair of orthotics during a 6-month period from the original invoice date. The program provides a replacement pair of orthotics at a 33% discount. To qualify, this form must be completed in full and faxed or emailed for approval. Please allow 2-business days for approval.

** PLEASE SEND COMPLETED FORM, A COPY OF THE ORIGINAL PRESCRIPTION FORM FOR THE INITIAL ORTHOTIC ORDER & A COPY OF THE LAB INVOICE.

** IN ORDER TO QUALIFY, THE PATIENT MUST BE UNDER THE AGE OF 12.

DETAILS

❑ INITIAL PAIR ❑ REPLACEMENT PAIR

DATE OF ORIGINAL INVOICE:

(DD/MM/YYYY)

DATE OF REQUEST:

(DD/MM/YYYY)

NOTES

OFFICE USE ONLY

Date of original invoice: _____
(DD/MM/YYYY)

Date of Request: _____
(DD/MM/YYYY)

Age of patient: _____

Approved by: _____