Print Form

BOSTON SOFT SPINAL ORTHOSIS ORDER FORM

Date: _____ Due Date: _____ Contact: _____

Ship To: _____ Account: _____ Phone: _____

Address: _____ PO#: _____ Fax: _____

City: _____ State: _____ Zip: _____ Ship Via: _____ Email: _____

Patient Name: _____

Age: _____ Sex: _____ Ht: _____ Wt: _____ Diagnosis: _____

Scan Label: _____

Impression

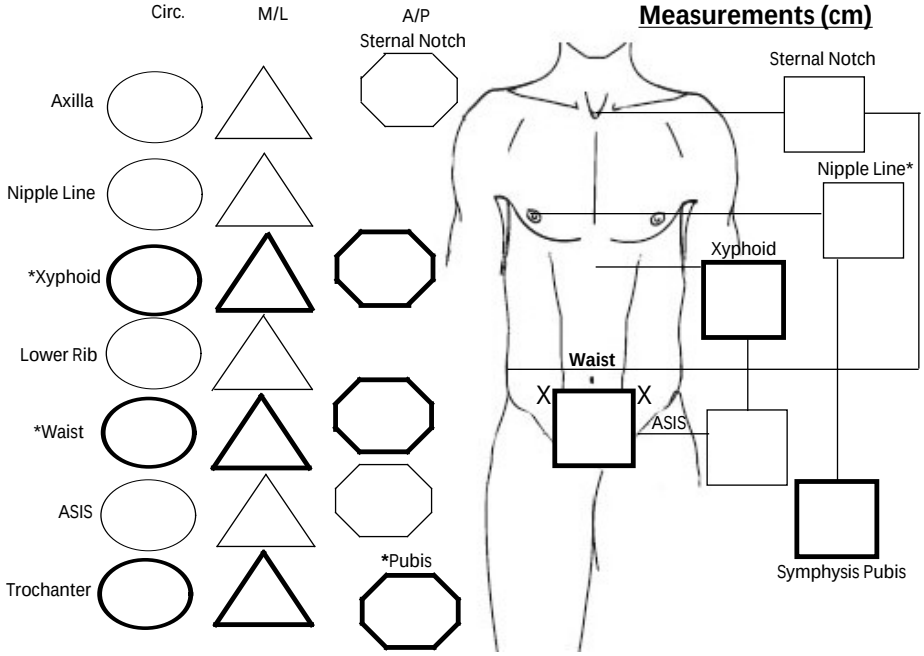
☐ Scan ☐ Cast ☐ Measure only

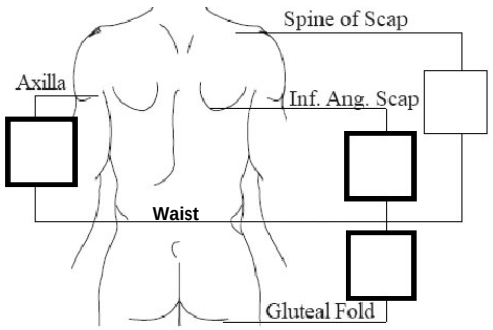
☐ Reduce to hand measures

Modifications

☐ As is ☐ 50% ☐ Full Symmetry

Measurements (cm)





	G-tube Relief	Baclofen Pump Relief
Waist to Device:	_____	_____
Center to Device:	_____	_____
Pt's Side:	☐ Left ☐ Right	☐ Left ☐ Right

☐ Cut out

☐ Build Breasts into orthosis Cup size: ___

*Waist to Nipple Line required for breast buildup

Lordosis

☐ As is

☐ 15°

☐ Other: _____

Abdominal Compression

☐ 10° from neutral

☐ 10° from Pt. presentation

☐ Neutral

☐ Other: _____

Abdominal Relief*

☐ S ☐ M

☐ L ☐ XL

*if relief is required, please include A/P measures at xyphoid, waist and pubis

Opening

☐ Anterior

☐ Posterior

☐ Bivalve

☐ Lateral: ☐ Left ☐ Right

Aliplast

Inner Soft: ☐ 1/8" ☐ **3/16"** ☐ 1/4"

Outer Firm: ☐ **1/8" white**

☐ 3/16" Foam Color: _____

Structure

Frame: ☐ Internal

☐ External Transfer: _____

Stays: ☐ Permanent

☐ Removable

MPE: ☐ **1/8"** ☐ 5/32"

Copoly: ☐ 1/8" ☐ 5/32"

Overlaps

☐ Tongue: 1/8" Firm Aliplast

☐ Smooth

☐ Butting

☐ None

Finished: ☐ Yes ☐ No ☐ Finish to tech discretion

(If yes, please complete all fields in **BOLD**)

☐ LSO ☐ TLSO

Finish Heights (from waist)

Sternal Notch:	_____	Spine of Scap:	_____
Xyphoid:	_____	Axilla:	_____
Pubis:	_____	Inf Angle Scap:	_____
		Seat:	_____

Straps: ☐ **Standard- White** ☐ Black

Previous Wearer: ☐ Yes ☐ No

Rev. 7 4/17

Notes:

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