Print Form

Boston Soft Scoliosis 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

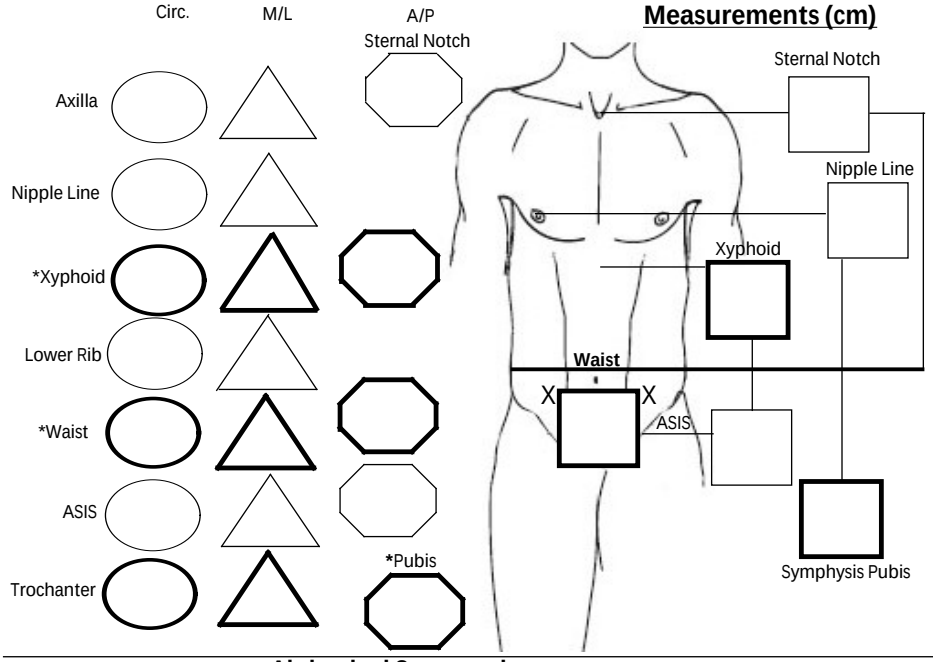
☐ Scan ☐ Cast ☐ Measure only

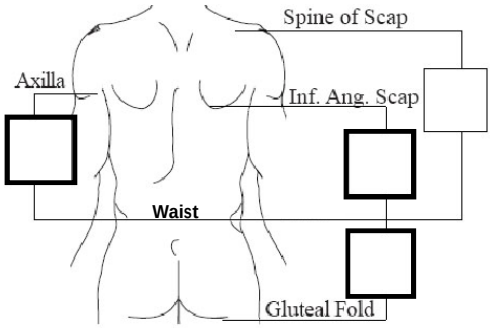
☐ Reduce to hand measures

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

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

Lumbar Relief

☐ Left ☐ Right

Lumbar Reinforcement

☐ Left ☐ Right

Opening

☐ Anterior

Tongue: ☐ 1/8" aliplast

☐ Posterior

Aliplast

Inner Soft: ☐ 1/8" ☐ **3/16"** ☐ 1/4"

Outer Firm: ☐ **1/8" white** ☐ 3/16" Foam Color: _____

Frame

☐ Internal ☐ External Transfer: _____

MPE: ☐ **1/8"** ☐ 5/32"

Copoly: ☐ 1/8" ☐ 5/32"

Notes:

Brace Design

Prokyphotic Extension:	☐ Left	☐ Right
Axilla:	☐ Left	☐ Right
Thoracic Extension:	☐ Left	☐ Right
Thoracic Pad:	☐ Left	☐ Right
Thoracic Window:	☐ Left	☐ Right
Gusset:	☐ Left	☐ Right
Lumbar Pad:	☐ Left	☐ Right
Trochanter Extension:	☐ Left	☐ Right
Trochanter Pad:	☐ Left	☐ Right

Finished: ☐ Yes ☐ No ☐ Finish to tech discretion

(If yes, please provide X-ray and complete all fields in **BOLD**)

Finish Heights (from waist)

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

Straps: ☐ **Standard- White** ☐ Black

Pads: ☐ Yes ☐ No ☐ Send

Previous Wearer: ☐ Yes ☐ No

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