

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)

Measurements (cm)

Circ. M/L A/P

Sternal Notch

Axilla

Nipple Line

*Xyphoid

Lower Rib

*Waist

ASIS

Trochanter

Sternal Notch

Nipple Line*

Xyphoid

Waist

ASIS

Symphysis Pubis

Axilla

Spine of Scap

Inf. Ang. Scap

Waist

Gluteal Fold

G-tube 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

Stays: Permanent Removable

Frame: Internal External Transfer: _____

MPE: **1/8"** 5/32"

Copoly: 1/8" 5/32"

Overlap

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

Notes: