

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) *"Anatomical LENGTHS taken from waist"*

Circ. M/L A/P

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 _____
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
 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:

Rev. 9 7/17