

BOSTON 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: _____

Measurements (cm)

	Circ.	M/L	A/P
Axilla			
Nipple Line			
*Xyphoid			
Lower Rib			
*Waist			
ASIS			
Trochanter			

Impression

Scan Cast Measure Only

Reduce to hand measures

Scan Label: _____

<p>Lordosis</p> <p><input type="checkbox"/> Standard- 15°</p> <p><input type="checkbox"/> Other: _____</p>	<p>Abdominal Compression</p> <p><input type="checkbox"/> Standard- 10° from neutral</p> <p><input type="checkbox"/> 10° from Pt. presentation</p> <p><input type="checkbox"/> Neutral</p> <p><input type="checkbox"/> Other: _____</p>	<p>Abdominal Relief*</p> <p><input type="checkbox"/> S <input type="checkbox"/> M</p> <p><input type="checkbox"/> L <input type="checkbox"/> XL</p> <p><small>*if relief is required, please include A/P measures at xyphoid, waist and pubis</small></p>	<p>Lumbar Relief</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Right</p> <p>Lumbar Reinforcement</p> <p><input type="checkbox"/> Left <input type="checkbox"/> Right</p>
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Notes:

<p>Liner</p> <p><input type="checkbox"/> Standard- 3/16" alipast</p> <p><input type="checkbox"/> Other: _____</p>	<p>Plastic</p> <p><input type="checkbox"/> Standard- Copoly sized to model</p> <p><input type="checkbox"/> Other: _____</p>	<p>Transfer</p> <p>Brace: _____</p> <p>Gusset: _____</p>
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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

iButton: Standard- Yes No Foam only

Pads: Yes No Send

Previous Wearer: Yes No