Print Form

BOSTON SCOLIOSIS ORDER FORM

Date: _____ Due Date: _____ Contact: _____

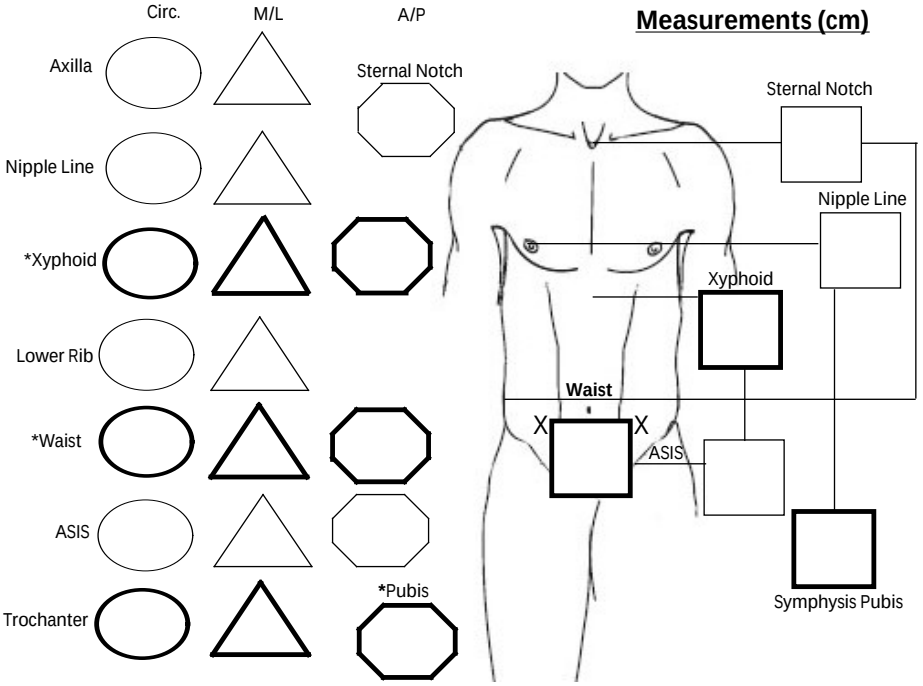
Ship To: _____ Account: _____ Phone: _____

Address: _____ PO#: _____ Fax: _____

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

Patient Name: _____

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

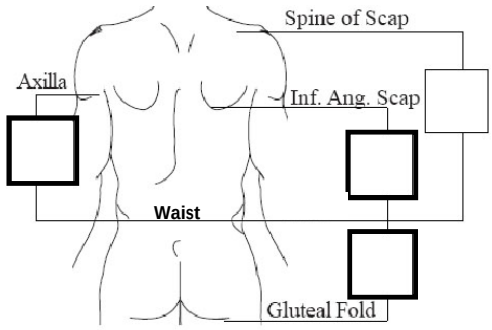


Impression

☐ Scan ☐ Cast ☐ Measure Only

☐ Reduce to hand measures

Scan Label: _____



Lordosis

☐ **Standard- 15°**

☐ Other: _____

Abdominal Compression

☐ **Standard- 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

Liner

☐ **Standard- 3/16" alipast**

☐ Other: _____

Plastic

☐ **Standard- Copoly sized to model**

☐ Other: _____

Transfer

Brace: _____

Gusset: _____

Scoli T's (Customer Service will determine the right size for your patient based off the measurements provided)

☐ White ☐ Single

☐ Silver ☐ Double

Quantity: ___

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

iButton: ☐ **Standard- Yes** ☐ No ☐ Foam only

Pads: ☐ Yes ☐ No ☐ Send

Previous Wearer: ☐ Yes ☐ No

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