Print Form

BOSTON BRACE 3D ORDER FORM

Date: _____ Due Date: _____ Contact: _____

Ship To: _____ Account: _____ Phone: _____

Address: _____ PO#: _____ Fax: _____

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

Patient Name: _____ First Time Wearer: ☐ Yes ☐ No

If no, specify Troch/Axillary

Age: _____ Sex: ▼ Ht: _____ ft. _____ in. Wt: _____ lbs. Diagnosis: ▼

Axillary Extension: ☐ Left ☐ Right

Troch Extension: ☐ Left ☐ Right

**Bivalve scans require measurements below

Circ. M/L A/P

Axilla

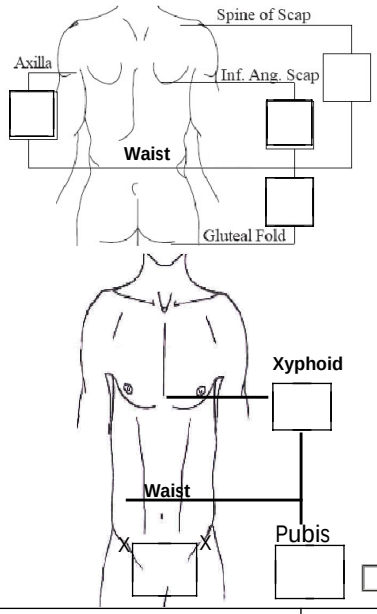
Xyphoid

Waist

Pubis

Trochanter

Measurements (cm)



☐ ASIS anterior lateral relief

Scan Label: _____

	Lumbar/TL	Thoracic
Apical vertebra		
Cobb angle		
Scoliometer reading		

Chart completion **Necessary** for brace fabrication

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

☐ White ☐ Single

☐ Silver ☐ Double

Quantity: _____

Opening

☐ **Posterior**

☐ Anterior

Liner

☐ **3/16" aliplast**

☐ Unlined

☐ 1/8" Partial liner

Plastic

☐ **5/32" copoly**

☐ Other: _____

Transfer

Lumbar Reinforcement: ☐ Yes ☐ No

Pads

☐ **.5" Installed**

☐ .5" un-installed

☐ Other: _____

Gusset:

☐ **No**

☐ Yes

Straps

☐ **White**

☐ Black

Boston Sensor

Send Sensor ☐ **Yes** ☐ No

Hole Size ☐ Boston Sensor

☐ iButton

☐ No hole

CLINICIAN ↑ **BOSTON O&P** ↓

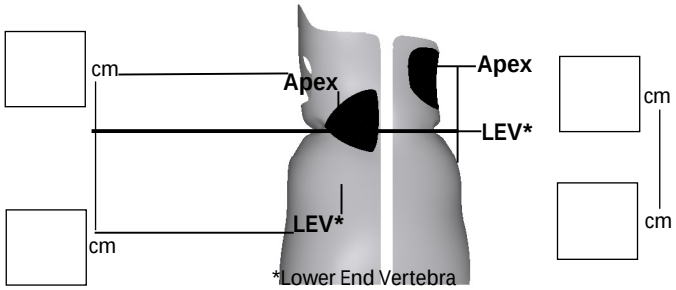
Lumbar / TL

☐ Left ☐ Right

TL Extension: ☐ Yes ☐ No

Height _____ cm

CAD specs determined by Boston O&P



Thoracic Extension

☐ Left ☐ Right

Height _____ cm

Axillary Modifications

☐ Left ☐ Right

☐ Outset Axilla: _____ mm

☐ Inset Axilla: _____ mm

Posterior Extension: ☐ Yes ☐ No

Finish Heights (from waist)

Xyphoid: _____ Axilla: _____

Pubis: _____ Inf Angle Scap: _____

Seat: _____

Troch ☐ Left ☐ Right

Notes:

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