

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

**Bivalue scans require measurements below

Measurements (cm)

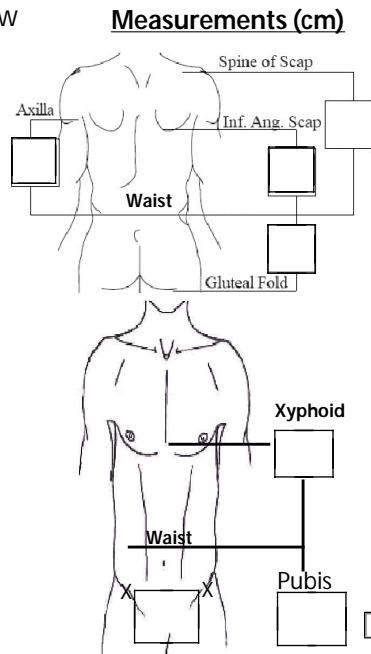
Circ. M/L A/P

Axilla

Xyphoid

Waist

Trochanter



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: _____

ASIS anterior lateral relief

Opening	Liner	Plastic	Transfer	Pads	Straps	Boston Sensor
<input type="checkbox"/> Posterior	<input type="checkbox"/> 3/16" aliplast	<input type="checkbox"/> 5/32" copoly		<input type="checkbox"/> .5" Installed	<input type="checkbox"/> No	<input type="checkbox"/> White
<input type="checkbox"/> Anterior	<input type="checkbox"/> Unlined	<input type="checkbox"/> Other: _____		<input type="checkbox"/> .5" un-installed	<input type="checkbox"/> Yes	<input type="checkbox"/> Black
	<input type="checkbox"/> 1/8" Partial liner			<input type="checkbox"/> Other: _____		
	Lumbar Reinforcement: <input type="checkbox"/> Yes <input type="checkbox"/> No					Send Sensor <input type="checkbox"/> Yes <input type="checkbox"/> No
						Hole Size For: <input type="checkbox"/> Boston Sensor
						<input type="checkbox"/> iButton
						<input type="checkbox"/> No hole

CLINICIAN ↑

BOSTON O&P ↓

Lumbar / TL	CAD specs determined by Boston O&P	Thoracic Extension
<input type="checkbox"/> Left <input type="checkbox"/> Right		<input type="checkbox"/> Left <input type="checkbox"/> Right
TL Extension: <input type="checkbox"/> Yes <input type="checkbox"/> No		Height <input type="text"/> cm
Height <input type="text"/> cm		

Axillary Modifications	Finish Heights (from waist)	Notes:
<input type="checkbox"/> Left <input type="checkbox"/> Right	Xyphoid: _____ Axilla: _____	
<input type="checkbox"/> Outset Axilla: _____ mm	Pubis: _____ Inf Angle Scap: _____	
<input type="checkbox"/> Inset Axilla: _____ mm	Seat: _____	
<input type="checkbox"/> Posterior Extension: <input type="checkbox"/> Yes <input type="checkbox"/> No	Troch <input type="checkbox"/> Left <input type="checkbox"/> Right	

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