

BOSTON BRACE 3D 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

Pubis

Scan Label: _____

Chart completion **Necessary** for brace fabrication

	Lumbar/TL	Thoracic
Apical vertebra		
Cobb angle		
Scoliometer reading		

Liner Standard - 3/16" aliplast Unlined Partial liner

Plastic Standard - 5/32" copoly Other: _____

Opening Posterior Anterior

Transfer Gusset: _____

Straps Standard- White Black

iButton Standard - Yes No Foam only

Previous Wearer: Yes No

CLINICIAN ↑

BOSTON O&P ↓

Lumbar / TL Left Right

TL Extension: Yes No

Height: _____ cm

CAD specs determined by Boston O&P

Apex _____ cm

LEV* _____ cm

Thoracic Left Right

Height: _____ cm

Brace Design

Modified Axilla: Left Right

Lateral Height: _____

Posterior Extension: Yes No

Outset Axilla: Left Right

Thoracic Extension: Left Right

Thoracic Window: Left Right

Trochanter Extension: Left Right

Finish Heights (from waist)

Xyphoid: _____ Axilla: _____

Pubis: _____ Inf Angle Scap: _____

Seat: _____

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

White Single Double

Silver Double

Quantity: _____

Notes:

Rev.13 3/19