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: ______

Circ. | M/L | A/P

Axilla

Nipple Line

Xyphoid

Lower Rib

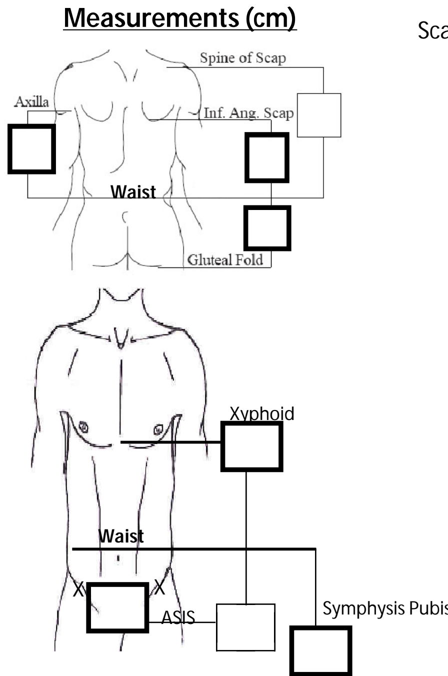
Waist

ASIS

Trochanter

Pubis

Measurements (cm)



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: ______

Liner
☐ **3/16" aliplast**
☐ Unlined
☐ Partial liner
Lumbar Reinforcement: ☐ Yes ☐ No

Plastic
☐ **5/32" copoly**
☐ Other: ______

Pads
☐ **.5" Installed**
☐ .5" un-installed
☐ Other: ______

Opening
☐ **Posterior**
☐ Anterior

Transfer
Brace: ______
Gusset: ______
Previous Wearer: ☐ Yes ☐ No

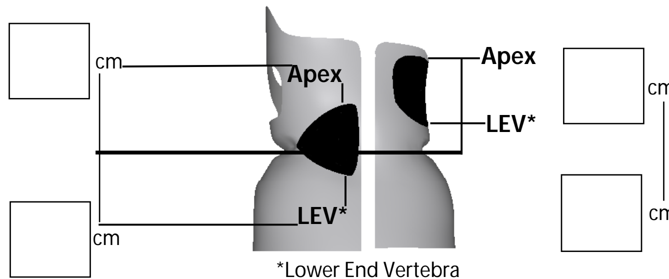
Straps
☐ **Std- White**
☐ Black

iButton
☐ **Std - Yes**
☐ No
☐ Foam only

CLINICIAN ⇧ **BOSTON O&P** ⇩

Lumbar / TL
☐ Left ☐ Right
TL Extension: ☐ Yes ☐ No
Height: ______ cm

CAD specs determined by Boston O&P



*Lower End Vertebra

Thoracic
☐ Left ☐ Right
Height: ______ cm

Axillary Modifications
☐ Left ☐ Right
☐ Outset Axilla: ______ mm
☐ Inset Axilla: ______ mm
Lateral Height: ______ cm
Posterior Extension: ☐ Yes ☐ No

Finish Heights (from waist)
Xyphoid: ______ Axilla: ______
Pubis: ______ Inf Angle Scap: ______
Seat: ______
Troch ☐ Left ☐ Right

Notes:

Rev.18 6/19

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