Print Form

Boston Brace Baby Order Form

Date: _____ Due Date: _____ Contact: _____

Ship To: _____ Account: _____ Phone: _____

Address: _____ PO#: _____ Fax: _____

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

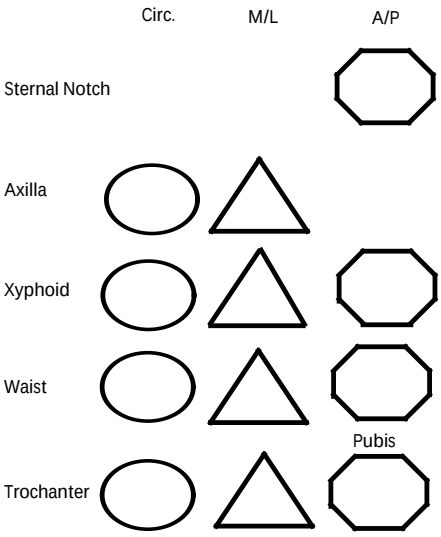
Patient Name: _____ First Time Wearer: ☐ Yes ☐ No

If no, specify Troch/Axillary:

Age: _____ Sex: _____ Ht: _____ ft. _____ in. Wt: _____ lbs. Diagnosis: _____ Axillary Extension ☐ Left ☐ Right

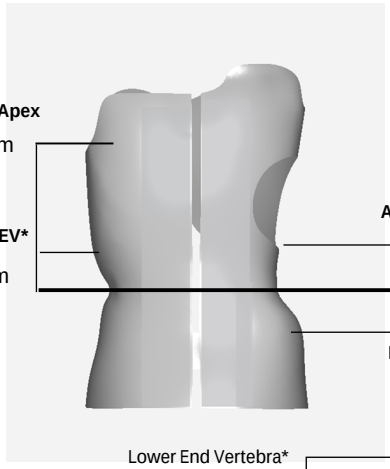
Troch Extension ☐ Left ☐ Right

Measurements (cm)



CAD

Scan Label: _____



Thoracic Extension

☐ Left ☐ Right

Height _____ cm

Lumbar / TL

☐ Left ☐ Right

Apex _____ cm

LEV* _____ cm

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

Plastic

☐ **1/8" copoly**
☐ Other: _____

Transfer

Brace: _____

Pads

☐ **.5" Installed**
☐ .5" un-installed
☐ Other: _____

Gusset

☐ **No**
☐ Yes

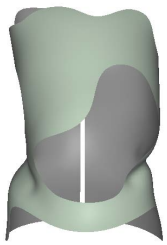
Straps

☐ **White**
☐ Black

Boston Sensor

Send Sensor ☐ **Yes** ☐ No

Hole Size For: ☐ Boston Sensor ☐ iButton ☐ No hole



Abdominal Window:

☐ **Yes**
☐ No

Thoracic Window:

☐ **Yes**
☐ No

Notes:

Finish Heights (from waist)

Sternal: _____ Axilla: _____

Pubis: _____ Spine of Scap: _____

Seat: _____

Troch ☐ Left ☐ Right

Finishing

Posterior opening ONLY
Anterior window sized to patient model

Rev. 19 8/21

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