




BOSTON BRACE ORIGINAL ORDER FORM




Date: _____ Due Date: _____ Contact: _____
 Ship To: _____ Account: _____ Phone: _____
 Address: _____ PO#: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Ship Via: _____ Email: _____




Patient Name: _____ **Impression**
 Scan Standing Cast
 Age: _____ Sex: _____ Ht: _____ ft. _____ in. Wt: _____ lbs. Diagnosis: _____
 Measure only
 Previous Wearer: Yes No




Measurements (cm)




Circ. M/L A/P




Axilla   




Sternal Notch   




Nipple Line   




*Xyphoid   

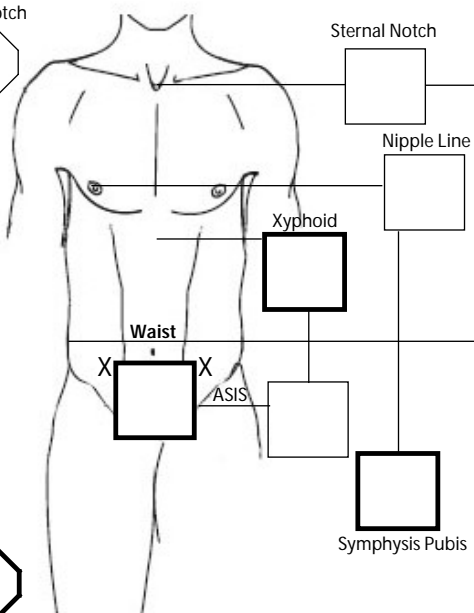
Lower Rib   

*Waist   

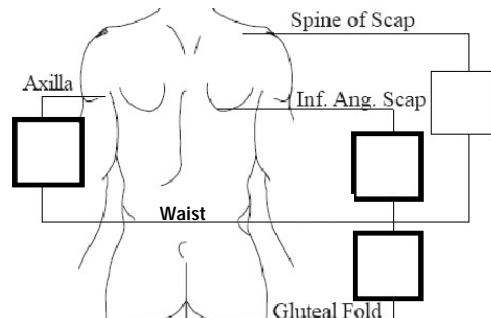
ASIS   

Trochanter   

*Pubis   



Scan Label: _____



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

White Single
 Silver Double

Quantity: _____

Lordosis
 Match scan/cast
 15°
 Other: _____

Abdominal Shape
 Neutral
 10° from neutral
 10° from Pt. presentation
 Other: _____

Abdominal Relief*
 S M
 L XL
 *if relief is required, please include A/P measures at xyphoid, waist and pubis

Lumbar Relief
 Left Right

Liner
 3/16" alipast Unlined
 Other: _____

Plastic
 Copoly sized to model
 Other: _____

Lumbar Reinforcement
 Left Right

Transfer
 Brace: _____

Brace Design (Optional)

Prokyphotic Extension: Left Right

Axilla: Left Right

Thoracic Extension: Left Right

Thoracic Pad: Left Right

Thoracic Window: Left Right

Gusset: Left Right

Lumbar Pad: Left Right

Trochanter Extension: Left Right

Trochanter Pad: Left Right

Finished: Yes No Finish to tech discretion
 (If yes, please provide X-ray and complete all fields in **BOLD**)

Finish Heights (from waist)

Sternal Notch: _____ Spine of Scap: _____

Xyphoid: _____ Axilla: _____

Pubis: _____ Inf Angle Scap: _____

Seat: _____

Straps: White Black

Pads: Yes No Send

Gusset: Yes No Send

iButton:

Send iButton Yes No

Drill Hole in Plastic Yes No

Foam cut out only

Notes:

Rev.11 9/20