Print Form

BOSTON MILWAUKEE ORDER FORM

Date: _____ Due Date: _____ Contact: _____

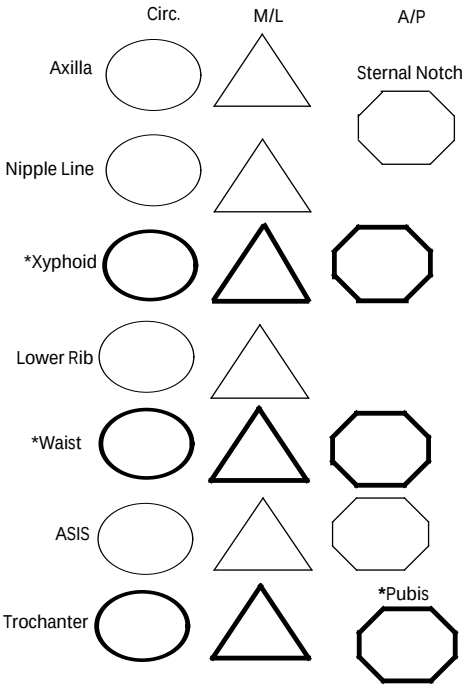
Ship To: _____ Account: _____ Phone: _____

Address: _____ PO#: _____ Fax: _____

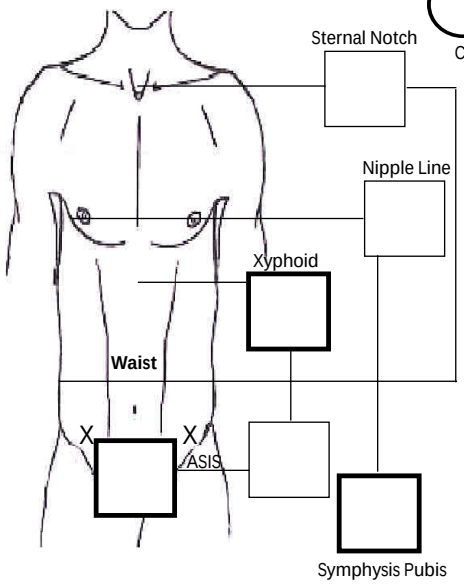
City: _____ State: _____ Zip: _____ Ship Via: _____ Email: _____

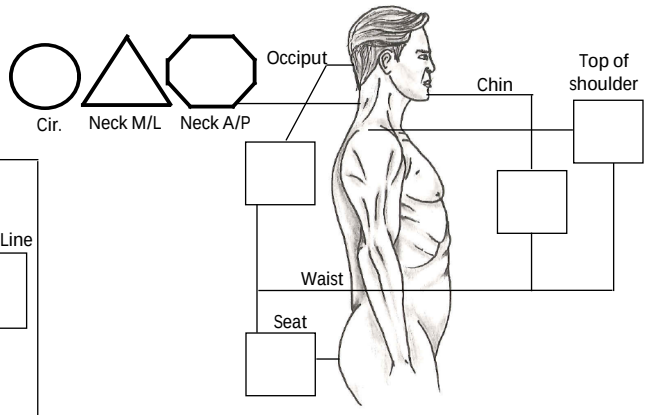
Patient Name: _____ **Diagnosis:** ☐ Scoliosis ☐ Kyphosis

Age: _____ Sex: _____ Ht: _____ Wt: _____



Measurements (cm)





Required Measurements

Low Profile	High Profile
☐ M/L and A/P at neck	☐ M/L and A/P at neck
☐ Neck circumference	☐ Neck circumference
☐ Waist to sternal notch	☐ Waist to occiput
☐ Waist to top of shoulder	☐ Waist to chin

Lordosis

☐ **Standard- 15°**

☐ Other: _____

Abdominal Compression

☐ Neutral

☐ Other: _____

Abdominal Relief*

☐ S ☐ M

☐ L ☐ XL

*if relief is required, please include A/P measures at xyphoid, waist and pubis.

Liner

☐ **Standard- 3/16" alipast**

☐ Other: _____

Plastic

☐ **Standard- Copoly sized to model**

☐ Other: _____

Transfer

Brace: _____

Gusset: _____

Straps

☐ **Standard- White**

☐ Black

Brace Design

☐ **Kyphosis design**
(M/L x-ray required)

- ☐ Static kyphosis pad / Pectoral extension
- ☐ Pectoral extension
- ☐ Floating kyphosis pad

☐ **Scoliosis design**
(A/P x-ray required)

- ☐ Floating axilla
- ☐ Shoulder ring
- ☐ Floating thoracic
- ☐ Static lumbar
- ☐ Troch pad

Notes:

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