BOSTON NOCTURNAL BRACE 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) in Supine

(all linear measures taken from waist)

	Circ.	M/L	A/P
Axilla			Sternal Notch
Nipple Line			
Xyphoid			
Lower Rib			
Waist			
ASIS			
Trochanter			Pubis

Xyphoid

Waist

X X

ASIS

Symphysis Pubis

Impression

☐ Scan Standing ☐ Cast ☐ Measure Only

☐ **Standard - Reduce to hand supine measures**

Scan Label: ______

Spine of Scap

Axilla*

Inf. Ang. Scap

Waist

Troch

*Taken at 35° or preferred bending for Boston Bending Brace

Lordosis

☐ **Standard - 15°**

☐ Other: ______

Abdominal Compression

☐ **Standard - Neutral**

☐ 10° from Pt. presentation

☐ Other: ______

Plastic

☐ **Standard - 1/8" copoly**

☐ Other: ______

Transfer

Brace: ______

☐ Tongue: **Standard - 1/16" PE Molded**

☐ Boston Night Shift Brace

Liner

☐ **Standard - 1/4" aliplast**

☐ Other: ______

☐ Boston Bending Brace

Liner

☐ **Standard - 1/2" aliplast on side**

☐ Other: ______

Bending

☐ **Standard - 35°**

☐ Other: ______ °

Brace Design

Axilla:	☐ Left	☐ Right
Thoracic Extension:	☐ Left	☐ Right
Thoracic Relief:	☐ Left	☐ Right
Lumbar Pad:	☐ Left	☐ Right
Trochanter Extension:	☐ 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)

Anterior		Posterior		Lateral	
Xyphoid:	____	Inf Angle Scap:	____	Axilla:	____
Pubis:	____			Thoracic Extension:	____
				Troch:	____

Straps: ☐ **Standard - White** ☐ Black

iButton: ☐ Yes ☐ No ☐ Foam only

Previous Wearer: ☐ Yes ☐ No

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Notes: