

# 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			
Nipple Line			
Xyphoid			
Lower Rib			
Waist			
ASIS			
Trochanter			

**Impression**

Scan Standing     Cast     Measure Only

**Standard - Reduce to hand supine measures**

Scan Label: \_\_\_\_\_

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

<p><b>Lordosis</b></p> <p><input type="checkbox"/> Standard - 15°</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Abdominal Compression</b></p> <p><input type="checkbox"/> Standard - Neutral</p> <p><input type="checkbox"/> 10° from Pt. presentation</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Plastic</b></p> <p><input type="checkbox"/> Standard - 1/8" copoly</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Transfer</b></p> <p>Brace: _____</p> <p><input type="checkbox"/> Tongue: <b>Standard - 1/16" PE Molded</b></p>
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<p><input type="checkbox"/> <b>Boston Night Shift Brace</b></p> <p>Liner</p> <p><input type="checkbox"/> Standard - 1/4" aliplast</p> <p><input type="checkbox"/> Other: _____</p>	<p><input type="checkbox"/> <b>Boston Bending Brace</b></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;"> <p>Liner</p> <p><input type="checkbox"/> Standard - 1/2" aliplast on side</p> <p><input type="checkbox"/> Other: _____</p> </td> <td style="width: 50%;"> <p>Bending</p> <p><input type="checkbox"/> Standard - 35°</p> <p><input type="checkbox"/> Other: _____</p> </td> </tr> </table>	<p>Liner</p> <p><input type="checkbox"/> Standard - 1/2" aliplast on side</p> <p><input type="checkbox"/> Other: _____</p>	<p>Bending</p> <p><input type="checkbox"/> Standard - 35°</p> <p><input type="checkbox"/> Other: _____</p>
<p>Liner</p> <p><input type="checkbox"/> Standard - 1/2" aliplast on side</p> <p><input type="checkbox"/> Other: _____</p>	<p>Bending</p> <p><input type="checkbox"/> Standard - 35°</p> <p><input type="checkbox"/> Other: _____</p>		

<p><b>Brace Design</b></p> <p>Axilla:            <input type="checkbox"/> Left    <input type="checkbox"/> Right</p> <p>Thoracic Extension:    <input type="checkbox"/> Left    <input type="checkbox"/> Right</p> <p>Thoracic Relief:        <input type="checkbox"/> Left    <input type="checkbox"/> Right</p> <p>Lumbar Pad:            <input type="checkbox"/> Left    <input type="checkbox"/> Right</p> <p>Trochanter Extension:    <input type="checkbox"/> Left    <input type="checkbox"/> Right</p>	<div style="border: 2px solid black; padding: 5px; margin-bottom: 10px;"> <p><b>Finished:</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Finish to tech discretion          (If yes, please provide X-ray and complete all fields in <b>BOLD</b>)</p> </div> <p><b>Finish Heights (from waist)</b></p> <table border="0" style="width: 100%;"> <thead> <tr> <th style="text-align: center;">Anterior</th> <th style="text-align: center;">Posterior</th> <th style="text-align: center;">Lateral</th> </tr> </thead> <tbody> <tr> <td>Xyphoid: _____</td> <td>Inf Angle Scap: _____</td> <td>Axilla: _____</td> </tr> <tr> <td>Pubis: _____</td> <td></td> <td>Thoracic Extension: _____</td> </tr> <tr> <td></td> <td></td> <td>Troch: _____</td> </tr> </tbody> </table> <p><b>Straps:</b>    <input type="checkbox"/> Standard - White    <input type="checkbox"/> Black</p> <p><b>iButton:</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Foam only</p> <p>Previous Wearer:    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	Anterior	Posterior	Lateral	Xyphoid: _____	Inf Angle Scap: _____	Axilla: _____	Pubis: _____		Thoracic Extension: _____			Troch: _____	<p><b>Notes:</b></p>
Anterior	Posterior	Lateral												
Xyphoid: _____	Inf Angle Scap: _____	Axilla: _____												
Pubis: _____		Thoracic Extension: _____												
		Troch: _____												