Print Form

Boston Nocturnal Brace Order Form

Date: _____ Due Date: _____ Contact: _____

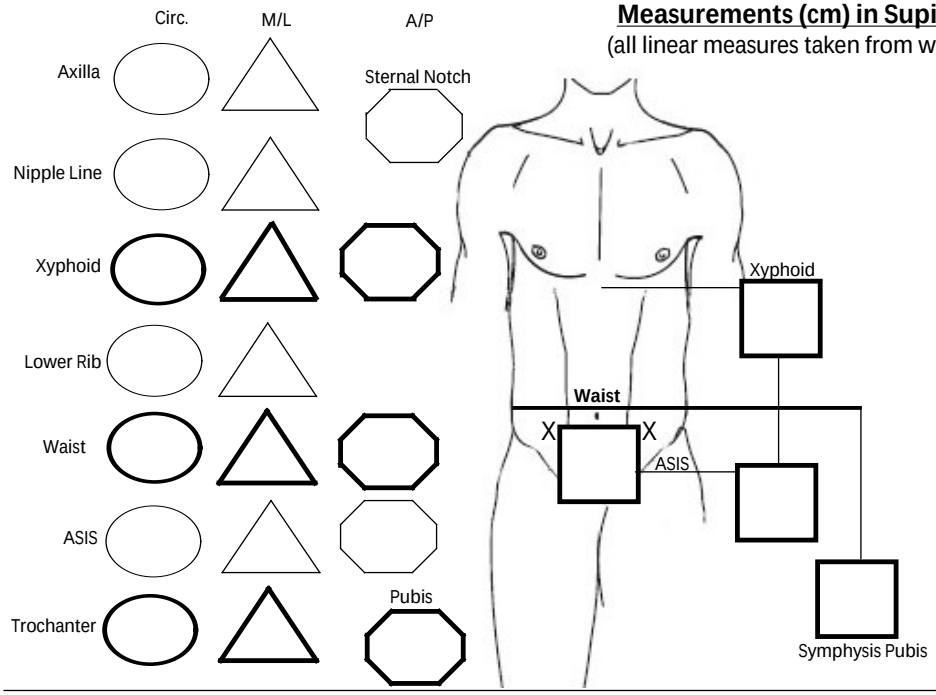
Ship To: _____ Account: _____ Phone: _____

Address: _____ PO#: _____ Fax: _____

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

Patient Name: _____

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



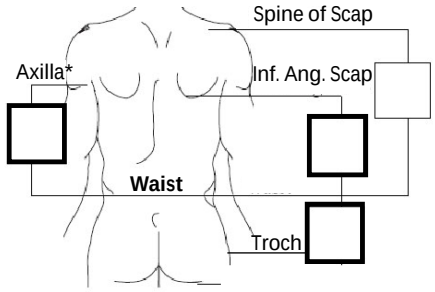
Measurements (cm) in Supine
(all linear measures taken from waist)

Impression

☐ Scan Standing ☐ Cast ☐ Measure Only

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

Scan Label: _____



*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

Rev. 14 8/18

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

☐ White ☐ Single

☐ Silver ☐ Double

Quantity: _____

Notes:

20 Ledin Dr., Avon, MA 02322 T: 800.262.2235 F: 800.634.5048 Email: customerservice@bostonoandp.com