BOSTON SOFT SPINAL ORTHOSIS CORRECTIVE

Date: ____________ Due Date: ____________ Contact: ____________

Ship To: ____________ Account: ____________ Phone: ____________

Address: ____________ PO#: ____________ Fax: ____________

City: ________ State: ______ Zip: ______ Ship Via: ____________ Email: ____________

Patient Name: ______________________________

Age: ____ Sex: ______ Ht: _____ ft. _____ in. Wt: _____ lbs. Diagnosis: ____________

Scan Label: ______________________________

Impression

☐ Scan ☐ Cast ☐ Measure only

☐ Reduce to hand measures ☐ 3D Mods (Scan Only)

Percent Correction

☐ As Is ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Measurements (cm) *Anatomical LENGTHS taken from waist*

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

Sternal Notch

Nipple Line*

Xyphoid

Waist

ASIS

Symphysis Pubis

Spine of Scap

Axilla

Inf. Ang. Scap

Waist

Gluteal Fold

	G-tube Relief	Baclofen Pump Relief
Waist to Device:	______	______
Center to Device:	______	______
Pt's Side:	☐ Left ☐ Right	☐ Left ☐ Right
	☐ Cut out	

☐ Build Breasts into orthosis Cup size: ______

*Waist to Nipple Line required for breast buildup

Abdominal Shape

☐ Neutral

☐ Match scan/cast

Relief: ☐ Small ☐ Medium ☐ Large

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

Abdominal Window

☐ **Yes** ☐ No

☐ Plastic only

☐ Foam and plastic

Window Type

☐ **Asymmetrical**

☐ Symmetrical

Lordosis

☐ 25 degrees

☐ Match scan/cast

☐ Other: ________

Kyphosis

☐ 25 degrees

☐ Match scan/cast

☐ Other: ________

Opening

☐ **Posterior**

☐ Anterior

☐ Tongue: 1/8" Firm

Liner

Inner Soft: ☐ **3/16"** ☐ 1/8" ☐ 1/4"

Outer Firm: ☐ **1/8" white** ☐ 3/16"

Foam Color: ________

Structure

☐ **External**

Transfer: ________

☐ Internal

Plastic

Copoly: ☐ **1/8"** ☐ 3/32" ☐ 5/32"

☐ Other: ________

Pads

☐ **.5 Installed**

☐ .5 Un-installed

☐ Other: ________

Straps:

☐ **White**

☐ Black

Axillary ☐ Left ☐ Right

Thoracic Extension ☐ Left ☐ Right Height ☐

Thoracic Window ☐ Yes ☐ No

☐ Plastic Only

☐ Foam and plastic

Lumbar/TL ☐ Left ☐ Right

TL Extension ☐ Yes ☐ No Height ☐

Troch Extension ☐ None ☐ Left ☐ Right

☐ TLSO or ☐ LSO

Axilla

Waist

Pubis

Seat:

☐ TLSO or ☐ LSO

Finished: ☐ Yes ☐ No ☐ Finish to tech discretion

If yes, provided finish measurements below in CM

Apex

LEV*

Apex

LEV*

*Lower End Vertebra

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

☐ White ☐ Single

☐ Silver ☐ Double

Quantity: ________

Notes:

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