

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					Sternal Notch	<input type="checkbox"/>
Nipple Line					Nipple Line*	<input type="checkbox"/>
Xyphoid					Xyphoid	<input type="checkbox"/>
Lower Rib					Waist	<input type="checkbox"/>
Waist					ASIS	<input type="checkbox"/>
ASIS					Symphysis Pubis	<input type="checkbox"/>
Trochanter						

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 <input type="checkbox"/> Neutral <input type="checkbox"/> Match scan/cast Relief: <input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large *if relief is required, please include A/P measures at xyphoid, waist and pubis	Abdominal Window <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Plastic only <input type="checkbox"/> Foam and plastic	Window Type <input type="checkbox"/> Asymmetrical <input type="checkbox"/> Symmetrical	Lordosis <input type="checkbox"/> 25 degrees <input type="checkbox"/> Match scan/cast <input type="checkbox"/> Other: _____	Kyphosis <input type="checkbox"/> 25 degrees <input type="checkbox"/> Match scan/cast <input type="checkbox"/> Other: _____
--	---	---	---	---

Opening <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior <input type="checkbox"/> Tongue: 1/8" Firm	Liner Inner Soft: <input type="checkbox"/> 3/16" <input type="checkbox"/> 1/8" <input type="checkbox"/> 1/4" Outer Firm: <input type="checkbox"/> 1/8" white <input type="checkbox"/> 3/16" Foam Color: _____	Structure <input type="checkbox"/> External Transfer: _____ <input type="checkbox"/> Internal	Plastic Copoly: <input type="checkbox"/> 1/8" <input type="checkbox"/> 3/32" <input type="checkbox"/> 5/32" <input type="checkbox"/> Other: _____	Pads <input type="checkbox"/> .5 Installed <input type="checkbox"/> .5 Un-installed <input type="checkbox"/> Other: _____	Straps: <input type="checkbox"/> White <input type="checkbox"/> Black
---	--	---	--	---	--

Axillary <input type="checkbox"/> Left <input type="checkbox"/> Right	Thoracic Extension <input type="checkbox"/> Left <input type="checkbox"/> Right Height <input type="checkbox"/>	Thoracic Window <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Plastic Only <input type="checkbox"/> Foam and plastic	Lumbar/TL <input type="checkbox"/> Left <input type="checkbox"/> Right	TL Extension <input type="checkbox"/> Yes <input type="checkbox"/> No Height <input type="checkbox"/>	Troch Extension <input type="checkbox"/> None <input type="checkbox"/> Left <input type="checkbox"/> Right
---	---	--	--	---	--

Finished: Yes No Finish to tech discretion
 If yes, provided finish measurements below in CM

<input type="checkbox"/> TL SO	<input type="checkbox"/> TL SO
OR	OR
<input type="checkbox"/> LS O	<input type="checkbox"/> LS O
Seat: <input type="checkbox"/>	<input type="checkbox"/> Pubis

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: