

BOSTON SOFT SPINAL ORTHOSIS POSTURAL

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

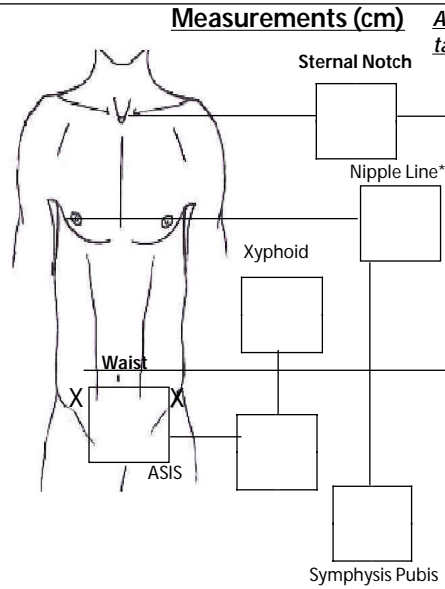
Scan Cast Measure only

Reduce to hand measures

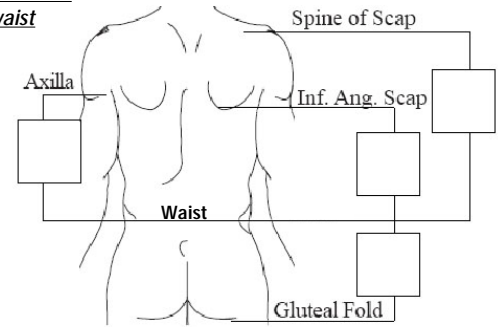
Percent Correction

As Is 25% 50% 75% 100%

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



Measurements (cm) Anatomical LENGTHS taken from waist



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

Lordosis

25 degrees
 Match scan/cast
 Other: _____

Kyphosis

25 degrees
 Match scan/cast
 Other: _____

Opening

Anterior
 Posterior
 Bivalve

Overlap

Tongue: 1/8" Firm
 Smooth
 Butting
 None

Liner

Inner Soft: 3/16" 1/8" 1/4"
 Outer Firm: 1/8" white
 3/16"
 Foam Color: _____

Structure

Frame: External Internal

Transfer: (Ext Only)

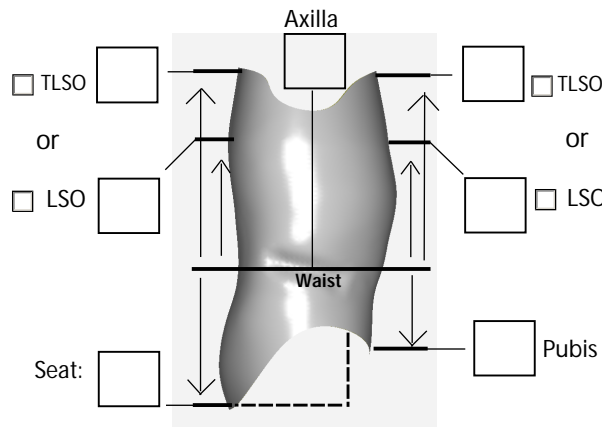
Copoly: 1/8" 3/32" 5/32"

MPE: 3/32" 1/8" 5/32"

Stays: Permanent Removable

Finished: Yes No Finish to tech discretion

If yes, provided finish measurements below in CM



Left
 Right
 None

Troch Ext. Right

Straps: White Black

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: