

Boston Baby Brace Order Form

Date: _____ Due Date: _____ PO #: _____ Contact: _____
 Ship To: _____ Ship Via: _____ Email: _____
 Address: _____ Account #: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Previous Boston Baby Wearer Scan Label: _____

Patient Name: _____ Ht: _____ft____in Wt: _____lbs
 Age: _____ Sex: _____ Diagnosis: _____

**Required	Lumbar/TL	Thoracic
Convexity	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right
Apical Vertebra		
Cobb Angle		
Scoliometer Reading		

Anatomical Measurements

*All measurements required

Shape Capture

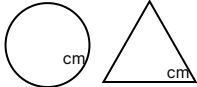
Scan Cast

Cir. M/L A/P

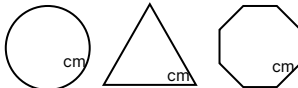
Sternal Notch



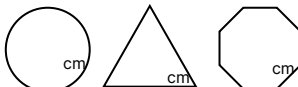
Axilla



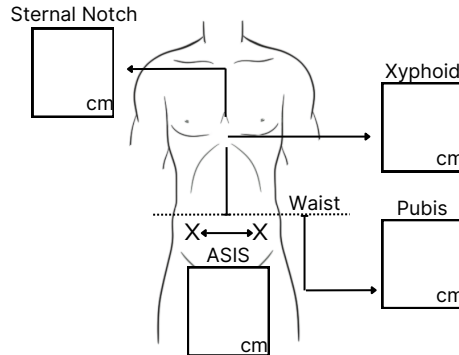
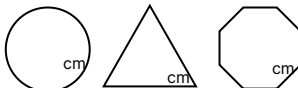
Xyphoid



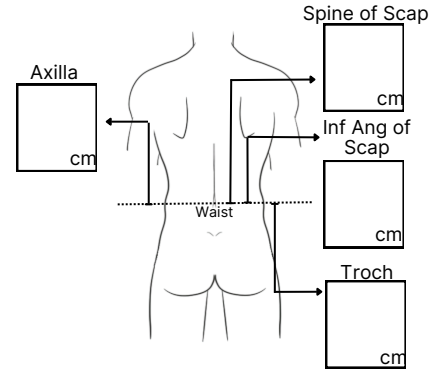
Waist



Trochanter



ASIS Anterior lateral relief



Brace Design

Liner

3/16" Aliplast

Other: _____

Plastic

1/8" Copoly

Other: _____

Straps

White

Black

Pads

.5" Installed

.5" Un-Installed

Unfinished Pads

1/8" Aliplast
Abdominal
Cover

Transfer

1st _____

2nd _____

Boston Sensor

Send Sensor

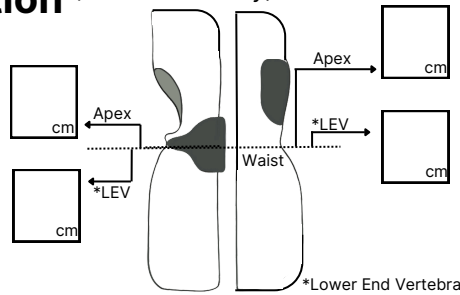
Sensor Hole

CAD Design Section (OPSB Staff Only)

Lumbar/TL

Left Right

TL Extension
Height _____cm



Thoracic Extension

Left Right

Height _____cm

Axillary Extension

Left Right

*Lower End Vertebra

LAB USE ONLY

CAD OVEN DESIGN



FINISH PADS QC



Finished Heights *from waist

Sternal Notch: _____cm Spine of Scap: _____cm

Pubis: _____cm Axilla: _____cm

Trochanter: _____cm

(Bilateral trochs are standard)

Scoli Tees

Single Double Qty: _____

Notes: