

Boston Brace Nightshift Order Form

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

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

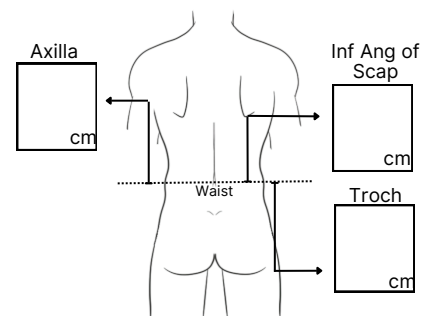
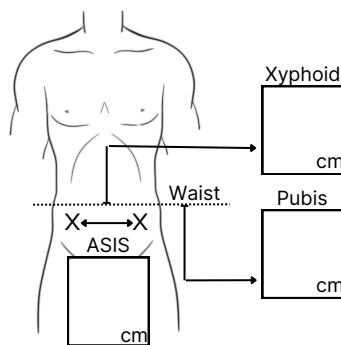
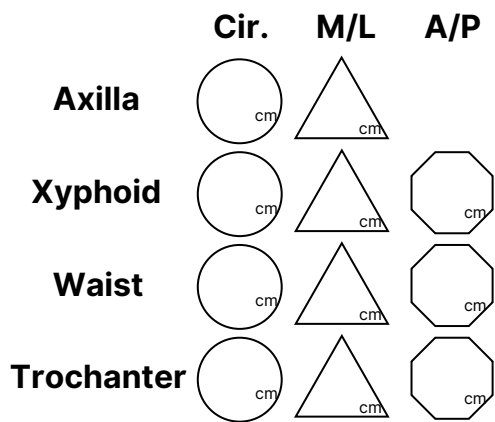
**Required	Lumbar/TL	Thoracic
Convexity	<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Left <input type="checkbox"/> Right
Apical Vertebra		
Cobb Angle		
Scolimeter Reading		

Anatomical Measurements

All measurements required in standing

Shape Capture

Scan Measure Only Cast



ASIS Anterior lateral relief

Brace Design

Abdominal Shape

Neutral
 Other: _____

Plastic

1/8" Copoly
 Other: _____

Straps

White
 Black

Liner

1/4" Aliplast
 Other: _____

Lordosis

15 degrees
 Other: _____

Transfer

1st _____
 2nd _____

Tongue 1/16" PE

Attached
 Send

Boston Sensor

Send Sensor
 Sensor Hole

CAD Design Section (Optional)

Apex T12- L1

Lumbar

Left Right

Push:

Shift:

Thoracolumbar

Left Right

Push:

Shift:

Thoracic Extension

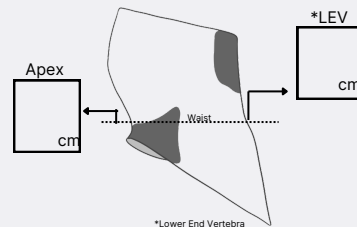
Left Right

Push:

Shift:

Axilla

Left Right



Trochanter

Left Right

Pad: 1/4"

Pad: 1/2" 1/4"

Sym

Pad: 1/2" 1/4"

Pad: 1/2" 1/4"

Sym

LAB USE ONLY

CAD OVEN DESIGN

FINISH PADS QC

Finished Heights *from waist

Xyphoid: _____cm Axilla: _____cm

Thoracic Ext: _____cm Trochanter: _____cm

Notes:

Scoli Tees

Single Double Qty: _____