




















Boston Brace Original Order Form

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

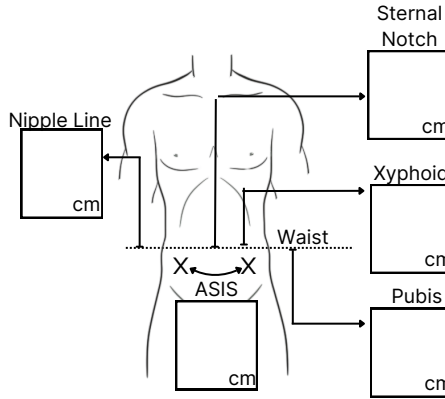
Patient Name: _____ Ht: _____ ft _____ in Wt: _____ lbs
 Age: _____ Sex: _____ Diagnosis: _____

Anatomical Measurements

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

Shape Capture

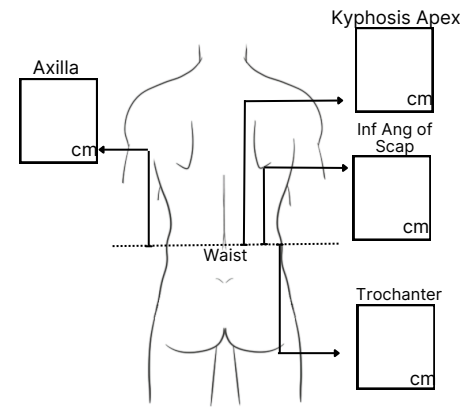
Scan Cast Measure Only



Kyphosis Options

Sternal Bar
 Pectoral Extensions

**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		



Lordosis

Match scan/cast
 15 degrees
 Other: _____

Abdominal Shape

Neutral
 10 degrees from Pt. presentation
 Other: _____

Lumbar Relief

Left Right

Straps

White
 Black

Finished

Yes
 No

Boston Sensor

Send Sensor
 Sensor Hole

Liner

3/16" Unlined
 Other: _____

Plastic

Copoly 5/32"
 Copoly 1/8"
 Other: _____

Lumbar Reinforcement

Transfer

1st _____
 2nd _____

Scoli Tees

Single Double
 Qty: _____

Brace Design (Optional)

	Left	Right
Prokyphotic Extension:	<input type="checkbox"/>	<input type="checkbox"/>
Axilla:	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Extension:	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Pad:	<input type="checkbox"/>	<input type="checkbox"/>
Thoracic Window:	<input type="checkbox"/>	<input type="checkbox"/>
Gusset:	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar Pad:	<input type="checkbox"/>	<input type="checkbox"/>
Trochanter Extension:	<input type="checkbox"/>	<input type="checkbox"/>
Trochanter Pad:	<input type="checkbox"/>	<input type="checkbox"/>

Finished Heights (From waist)

Sternal Notch: _____ cm Kyphosis Apex: _____ cm
 Thoracic Ext: _____ cm Axilla: _____ cm
 Xyphoid: _____ cm Inf Angle Scap: _____ cm
 Pubis: _____ cm Seat: _____ cm

Pads Yes No Send

Gusset Yes No Send

Notes:

LAB USE ONLY

CAD	OVEN	DESIGN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FINISH	PADS	QC
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>