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

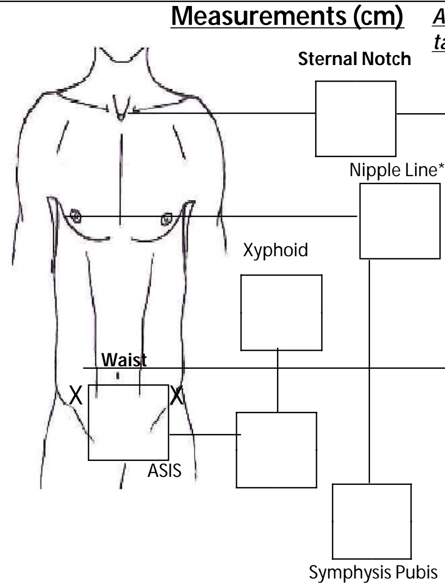
Percent Correction

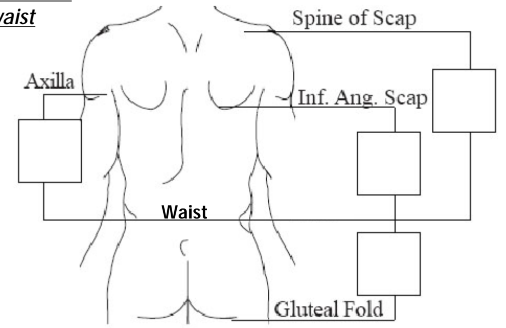
☐ As Is ☐ 25% ☐ 50% ☐ 75% ☐ 100%

Measurements (cm)

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

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) ____

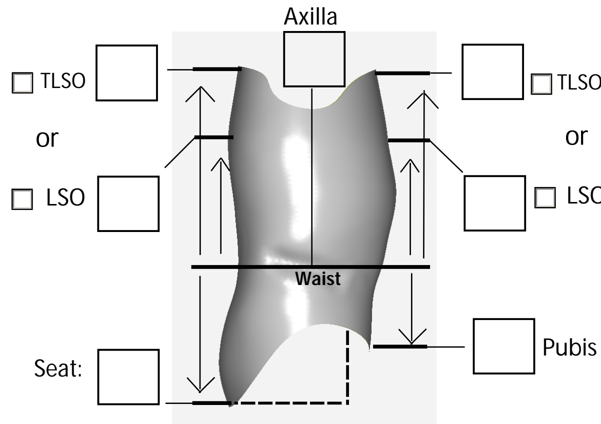
Copoly: ☐ **1/8"** ☐ 3/32" ☐ 5/32"

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



Troch Ext. ☐ Left ☐ Right ☐ None

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:

Rev. 24 8/20