Beställningsblankett Boston Scoliosis Night Brace

P.O.#_____

Date:_____

Delivery date:_____

Ship To:_____

Customer:_____

Prescriber/Orthotist:_____

Patient ID:_____ Age:_____ Height:_____ Sex:_____

Diagnosis:_____

Have patient used Boston Night Brace before: ☐Yes ☐No Date for last order/order no.:_____

Orthosis Design

Provide major curve: ☐Left ☐Right

Brace bending to: ☐Left ☐Right

Cobb Angles: _____ Lumbar_____Thoracic

Brace Options: *Opening is always anterior*

☐Removable liner ☐Permanent liner

Finished: ☐Yes ☐NO

Options: Transfer Pattern Number: _____

Curve Description

Thoracic curve: ☐Left ☐Right

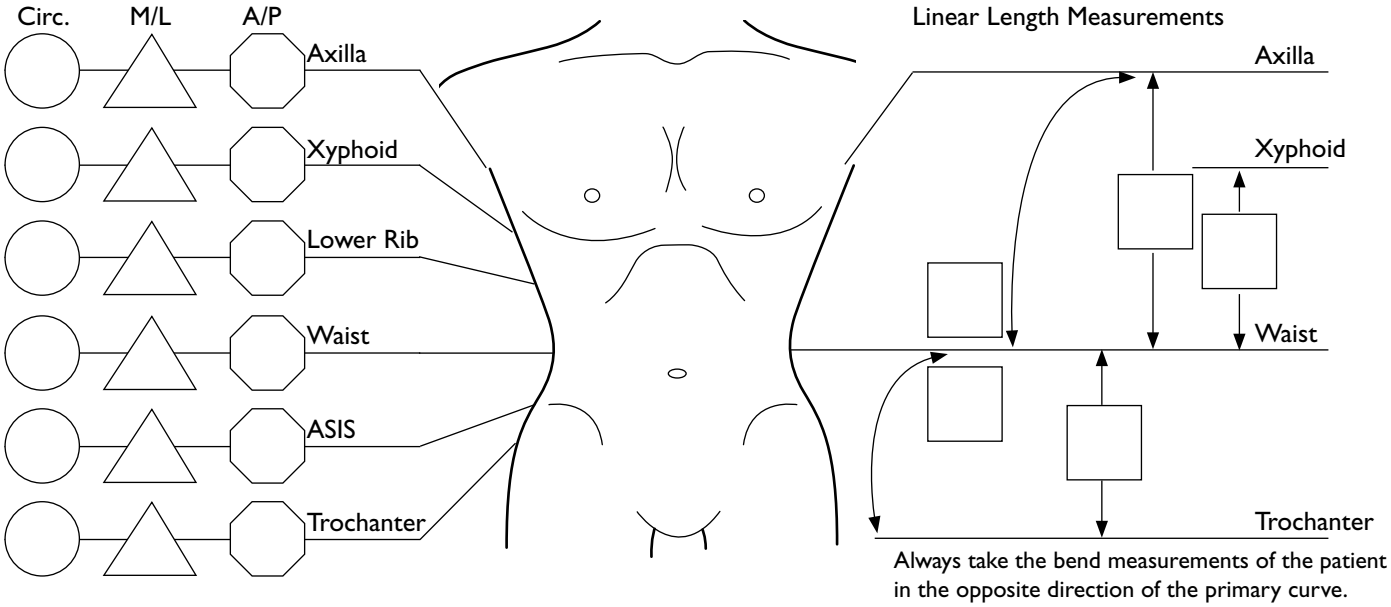
Lumbar curve: ☐Left ☐Right

Thoracic apex: Th-_____ Lumbar apex L-_____

Curve Type

☐Thoracic ☐Lumbar

☐Thoracolumbar ☐Double



Always take the bend measurements of the patient in the opposite direction of the primary curve.

NOTE: X-rays together with measurementform must be sent by e-mail.

Special instructions or remarks:

_____

_____

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