

Boston Brace 3D Order Form

Date: _____ Due Date: _____ PO #: _____ Contact: _____
 Ship To: _____ Ship Via: _____ Email: _____
 Address: _____ Account #: _____ Phone: _____
 City: _____ State: _____ Zip: _____ Previous 3D Wearer Scan Label: _____

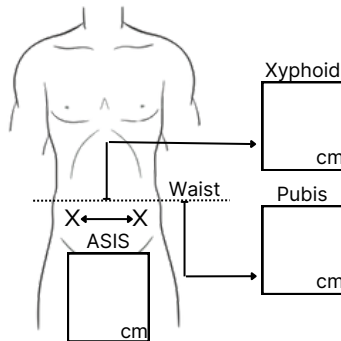
Patient Name: _____ Ht: _____ft_____in Wt: _____lbs
 Age: _____ Sex: _____ Diagnosis: _____

**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		

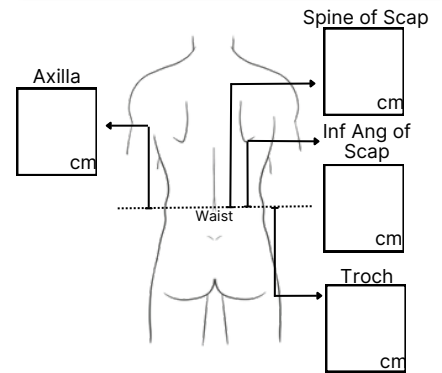
Anatomical Measurements

*All measurements required for BIVALVE SCANS

	Cir.	M/L	A/P
Axilla			
Xyphoid			
Waist			
Trochanter			



ASIS Anterior lateral relief



Brace Design

Opening

- Posterior
 Anterior w/tongue

Liner

- 3/16" Aliplast
 Unlined
 1/8" Partial Liner

Plastic

- 5/32" Copoly
 Other: _____

Straps

- White
 Black

Pads

- .5" Installed
 .5" Un-Installed
 Unfinished Pads

Lumbar Reinforcement

- Left Right

Transfer

1st _____
 2nd _____

Gusset

Boston Sensor

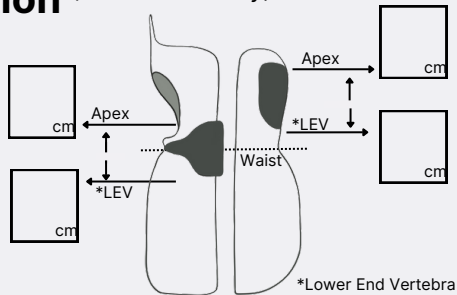
- Send Sensor
 Sensor Hole

CAD Design Section (OPSB Staff Only)

Lumbar/TL

- Left Right
 Pad Only

TL Extension
 Height _____cm



Thoracic Extension

Left Right
 Height _____cm

- 4-5 Pad
 TL Window

Axillary Modifications

Left Right
 Outset Axilla : _____mm
 Inset Axilla : _____mm

Posterior Extension

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"/>

Finished Heights *from waist

Xyphoid: _____cm Axilla: _____cm
 Pubis: _____cm Inf Ang Scap: _____cm
 Trochanter: _____cm
 Left Right

Scoli Tees

Single Double Qty: _____

Notes: