



Bestillingskjema 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

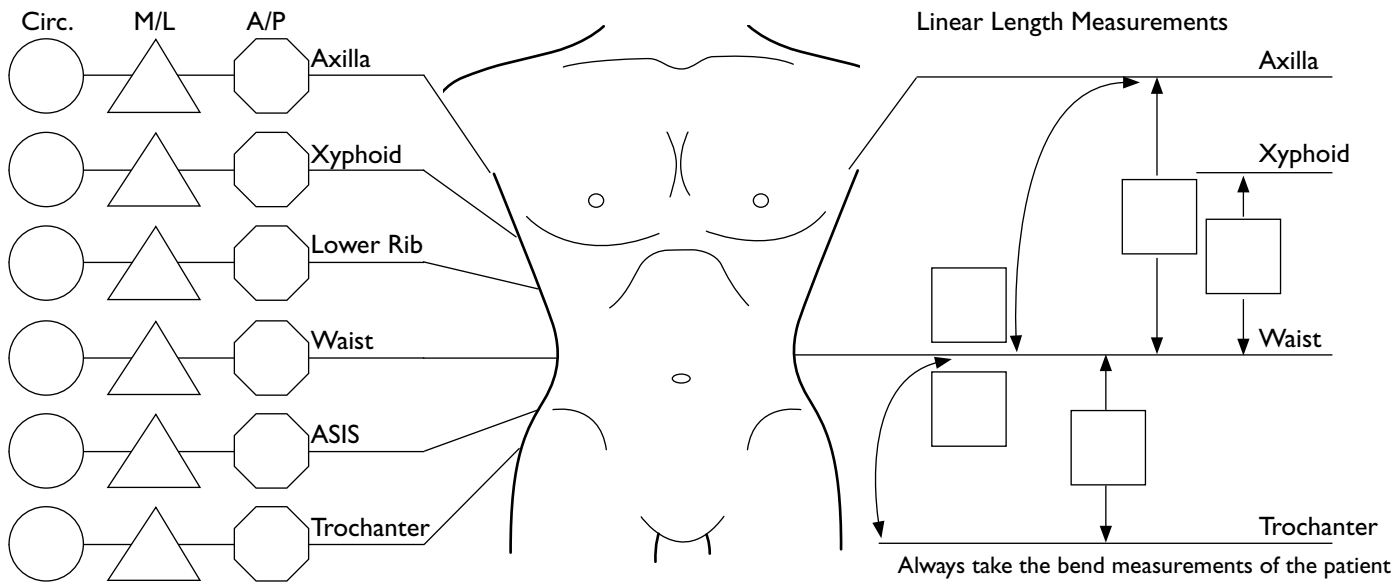
Lumbar curve: Left Right

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:

Ved å sende inn denne blanketten samtykker du i at personopplysninger behandles i henhold til GDPR (EU) 2016/679. Opplysningene benyttes kun i den utstrekning som kreves for å kunne levere bestilt produkt. Denne blanketten skal sendes via <https://submit.allardsupport.com> på grunn av krav om databeskyttelse fastsatt i GDPR (EU) 2016/679