PRO-TECH ORTHOPEDICS SCOLIOSIS MEASUREMENT FORM

CUSTOMER INFORMATION

COMPANY NAME

PO # ACCOUNT #

CONTACT PERSON

SHIP TO

PHONE FAX

REQUESTED DELIVERY DATE

SHIPPING PREFERENCE

PATIENT INFORMATION

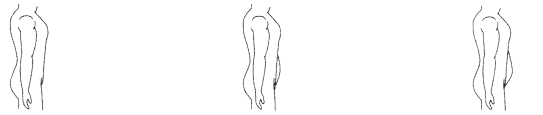
DATE

PATIENT NAME

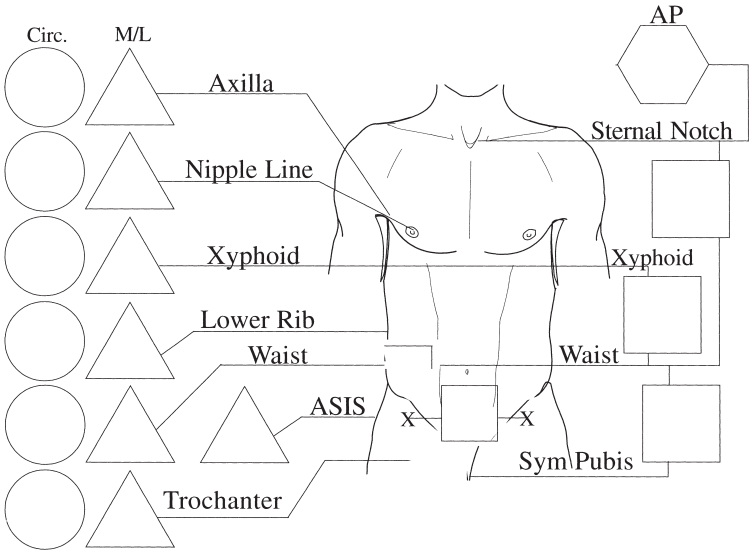
DIAGNOSIS

HEIGHT WEIGHT SEX AGE

– ABDOMINAL RELIEF –



☐ NEUTRAL ☐ SLIGHT ☐ MEDIUM



ORTHOSIS DESIGN

Type of Orthosis:
☐ LSO ☐ TLSO

Lordosis: ☐ 15˚ ☐ Other _____

Material: _____ Thickness: _____

Liner:
☐ 1/8" ☐ 3/16" ☐ 1/4"

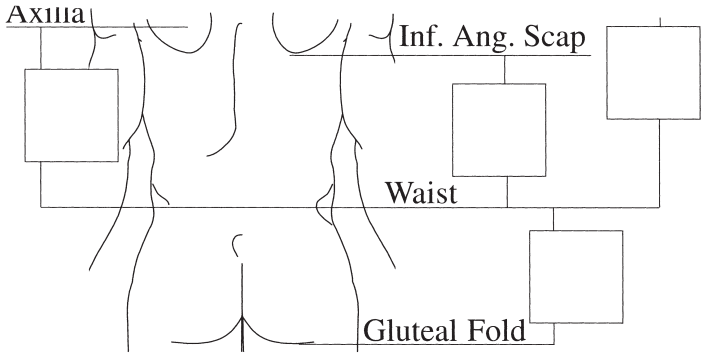
Opening:
☐ Anterior ☐ Posterior

Finished: ☐ Yes ☐ No

Options:
☐ Sternal Shield ☐ Axilla Straps
☐ Posterior Reinforcements ☐ Transfer Paper

Torso Sock: Size _____ Quantity _____

Special instructions or remarks: _____



Finished Measurements

Waist to Sternal Notch:	_____	Waist to Spine of Scapula:	_____
Waist to Xphoid:	_____	Waist to Inf. Angle:	_____
Waist to Pubis:	_____	Waist to Gluteal Fold:	_____
Waist to Axilla:	_____	Waist to Greater Trochanter:	_____

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Mold # _____ **Modified by** _____

Finished by _____