# PRO-TECH ORTHOPEDICS NIGHT TIME SCOLIOSIS MEASUREMENT FORM

## CUSTOMER INFORMATION

COMPANY NAME: _____

PO #: _____ ACCOUNT #_____

CONTACT PERSON: _____

SHIP TO: _____

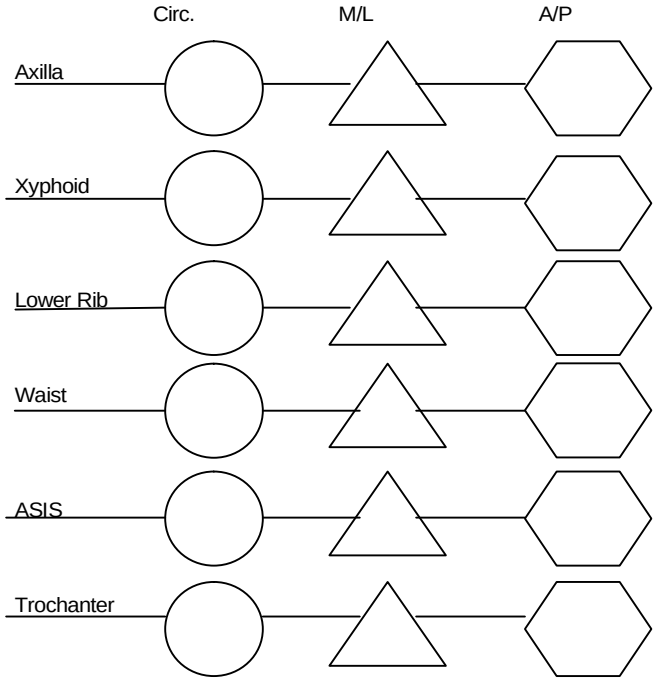
_____

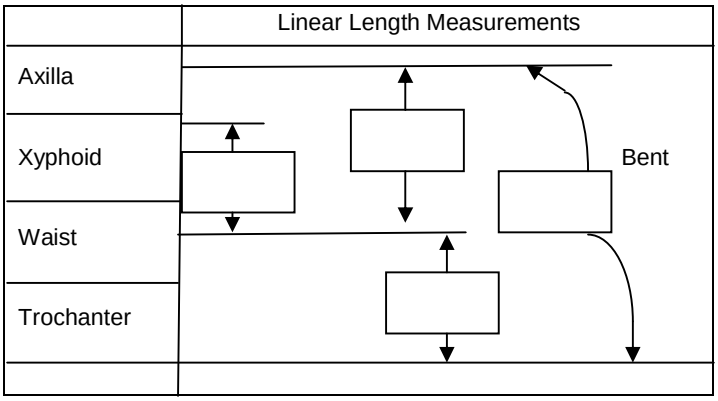
_____

PHONE:_____FAX:_____

REQUESTED DELIVERY DATE:_____

SHIPPING PREFERENCE:_____




## PATIENT INFORMATION

DATE: _____

PATIENT NAME:_____

DIAGNOSIS:_____

HEIGHT:_____ WEIGHT:_____ SEX:_____ AGE:_____

## ORTHOSIS DESIGN

Please Circle type of treatment:

King type: I, II, III, IV, VI

Or provide major curve: LT, RT, Double

Brace bending to: Left / Right

COBB Angles: _____ Lumbar _____ Thoracic

**Material:** High Definition thickness: 3/32

**Liner:** 3/16" soft foam laminated to 1/8" firm foam

**Opening:** Anterior

**Finished:** □□ Yes □□ No

**Options:** □□ Transfer Paper _____

**Torso Sock:** Size _____ Quantity _____

**Special instructions or remarks:** _____

_____

_____

_____

_____

_____

_____

Professional Technologies International, Inc.
95 Ryan Drive, Unit 8 • Raynham, MA 02767
Toll Free Phone: 866-819-1157 • Toll Free Fax 866-473-8105

**Office use only:**

**Mold #** _____ **Modified by** _____

**Finished by** _____