# Boston Baby Brace Order Form

Date:_____ Due Date:_____ PO #:_____ Contact:_____

Ship To:_____ Ship Via:_____ Email:_____

Address:_____ Account #:_____ Phone:_____

City:_____ State:_____ Zip:_____ ☐ Previous Boston Baby Wearer Scan Label:_____

Patient Name:_____ Ht: ____ft____in Wt:_____lbs

Age:_____ Sex:_____ Diagnosis:_____

| **Required | Lumbar/TL | Thoracic |
|---|---|---|
| Convexity | ☐Left ☐Right | ☐Left ☐Right |
| Apical Vertebra | | |
| Cobb Angle | | |
| Scoliometer Reading | | |

## Anatomical Measurements

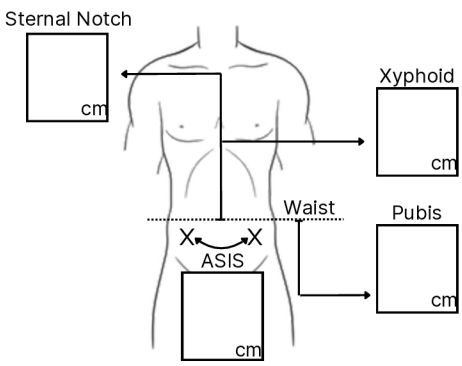
*All measurements required

| | Cir. | M/L | A/P |
|---|---|---|---|
| Sternal Notch | | | cm |
| Axilla | cm | cm | |
| Xyphoid | cm | cm | cm |
| Waist | cm | cm | cm |
| Trochanter | cm | cm | cm |

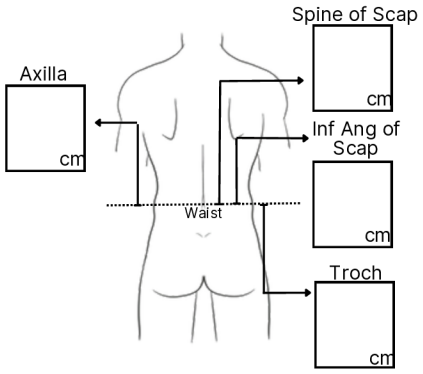
☐ ASIS Anterior lateral relief

**Shape Capture**

☐ Scan ☐ Cast




Anatomical LENGTHS taken from waist




## Brace Design

Liner
☐ **3/16" Aliplast**
☐ Other:_____

Plastic
☐ **1/8" Copoly**
☐ Other: _____

Transfer
1st_____
2nd_____

Straps
☐ **White**
☐ Black

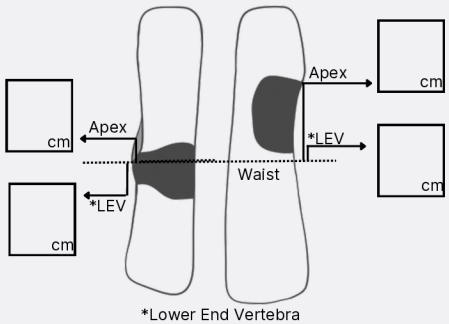
Pads
☐ **.5" Installed**
☐ .5" Un-Installed
☐ Unfinished Pads

## OPSB™ Sensor

☐ Send Sensor
☐ Sensor Hole

## CAD Design Section

Lumbar/TL
☐ Left ☐ Right




*Lower End Vertebra

Thoracic Extension
☐ Left ☐ Right
Height_____cm

Axillary Extension
☐ Left ☐ Right

## Scoli Tees

☐ Single
☐ Double
Qty: _____

## Finished Heights

*from waist

Sternal Notch:_____cm Spine of Scap: _____cm

Pubis: _____cm Axilla: _____cm

Trochanter: _____cm
(Bilateral trochs are standard)

## Notes:





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