

Boston Overlap Brace Order Form

Date: _____ Due Date: _____ PO #: _____ Contact: _____
 Ship To: _____ Ship Via: _____ Email: _____
 Address: _____ Account #: _____ Phone: _____
 City: _____ State: _____ Zip: _____ ☐ Previous BOB Wearer Scan Label: _____
☐ Use for reference only

Patient ID: _____ Ht: _____ ft _____ in Wt: _____ lbs
 Age: _____ Sex: _____ Diagnosis: _____

Anatomical Measurements

Shape Capture

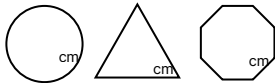
☐ Measure Only* ☐ Cast ☐ Scan
*All measurements required

Measurements taken:

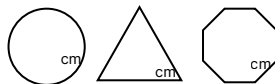
☐ Standing ☐ Supine
☐ Standard Reduction

Cir. M/L A/P

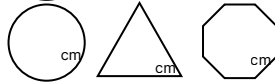
Xyphoid



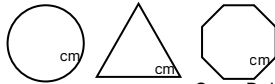
Waist



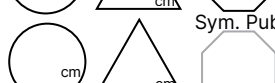
ASIS



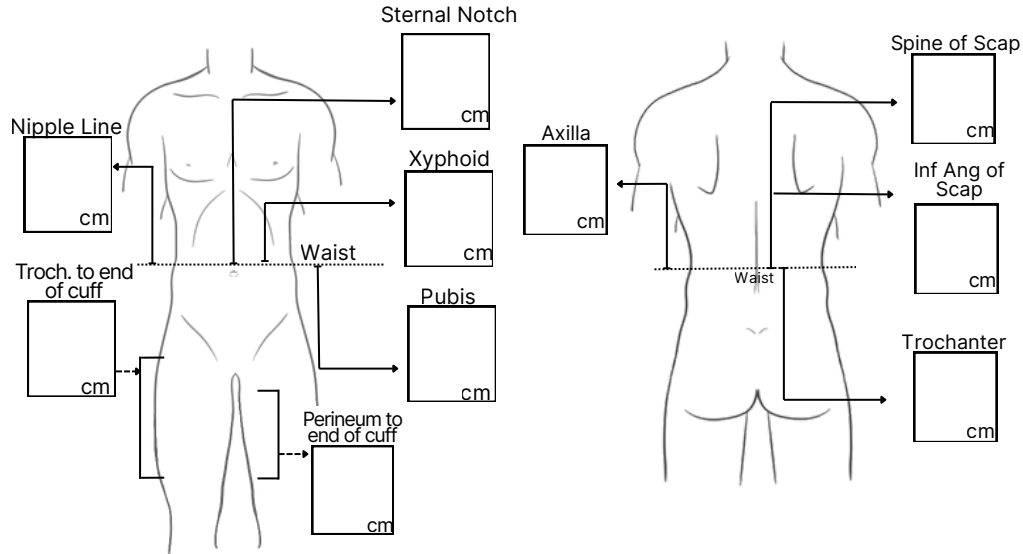
Trochanter



3" Distal to Perineum



3" Proximal to Knee Center



Anatomical LENGTHS taken from waist

Brace Modifications

Abdominal Shape

☐ 10° Abd. Compression
☐ Neutral
☐ Refer to measurements

Lordosis

☐ 15 degrees
☐ 0 degree
☐ Other: _____

Closure

☐ BOB Front
☐ Separate Straps

Brace Design

Liner

☐ Unlined
☐ 1/8"
☐ 3/16"
☐ 1/4"

Plastic

☐ 1/8" Polyethylene
☐ 5/32" Polyethylene
☐ Other: _____

Hip Spica Additions

Side:

☐ Left
☐ Right

Joint Type:

☐ Drop Lock
☐ B3-ROM

Cuffs:

☐ Detached
☐ Flexion: _____°
☐ Abduction: _____°

Scoli Tees

☐ Single
☐ Double
 Qty: _____

Finished Heights

Xyphoid: _____ cm Axilla: _____ cm
 Inf Ang Scap: _____ cm Mid Scap: _____ cm
 Pubis: _____ cm Gluteal Fold: _____ cm

Finish ☐ Yes ☐ OPSB Trim
☐ No ☐ Customer Trim

Notes: