

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

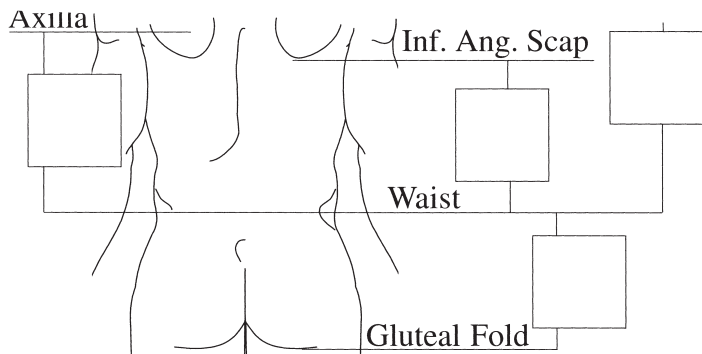
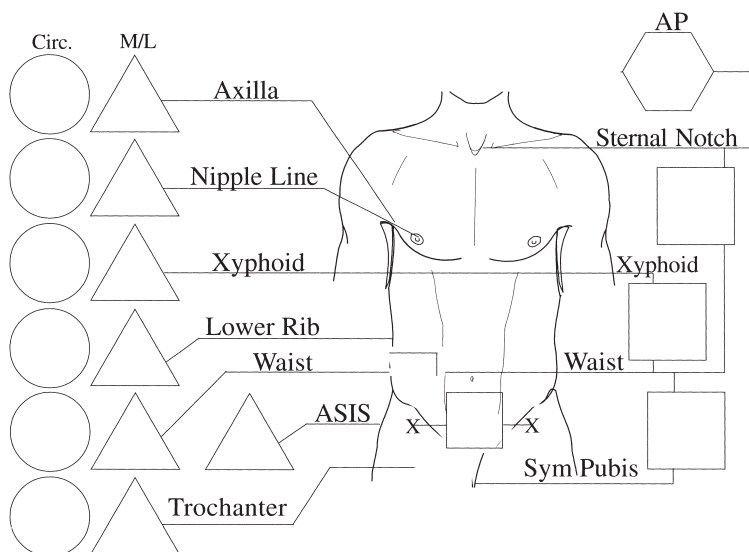
Finished: ☐ Yes ☐ No

Options:

☐ Sternal Shield ☐ Axilla Staps
☐ 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: _____