

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: _____

	Circ.	M/L	A/P
Axilla			
Xyphoid			
Lower Rib			
Waist			
ASIS			
Trochanter			

	Linear Length Measurements
Axilla	
Xyphoid	
Waist	
Trochanter	

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 _____