

Customer ID: _____ Order Date: _____ Date Needed: _____ PO#: _____

BILLING INFORMATION

Facility: _____ Contact Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

SHIPPING INFORMATION Same as Billing

Facility: _____ Contact: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

SHIPPING INSTRUCTIONS

Next Day Air 2nd Day Air 3rd Day Air Ground Local / Hand Delivery Scan Cast

PATIENT INFORMATION

Last Name: _____ First Name: _____

Male Female Age: _____ Weight: _____ Height: _____

Diagnosis: _____

Special Instructions: _____

FABRICATION INSTRUCTIONS

TYPE OF SPINAL ORTHOSIS

TLSO Corrective TLSO
 LSO Corrective LSO
 Bi-Valve

OPENING

Posterior Anterior W/Tongue

STRAPPING

Posterior Anterior

MODIFICATIONS

Lordosis Maintain Reduce Increase
 Abdomen Maintain Reduce Increase
 Thoracic Ext. Maintain Reduce Increase
 Correct Kyphosis Scoliosis Decomp
 ASIS Relief Yes

Other: _____

Transfer Paper: _____

MATERIALS

Plastic 1/4 Co-Poly
 3/16 Co-Poly
 5/32 Co-Poly
 1/8 Co-Poly

CORRECTIVE PADS

	Left	Right
Thoracic	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
Thoraco Lumbar	<input type="checkbox"/>	<input type="checkbox"/>
Axillary	<input type="checkbox"/>	<input type="checkbox"/>
Trapezius	<input type="checkbox"/>	<input type="checkbox"/>
Trochanteric	<input type="checkbox"/>	<input type="checkbox"/>
Kyphosis	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

LAB USE ONLY

Intake Date _____

Tracking Number _____

Modified Date _____

Technician _____

Shipped Date _____

