



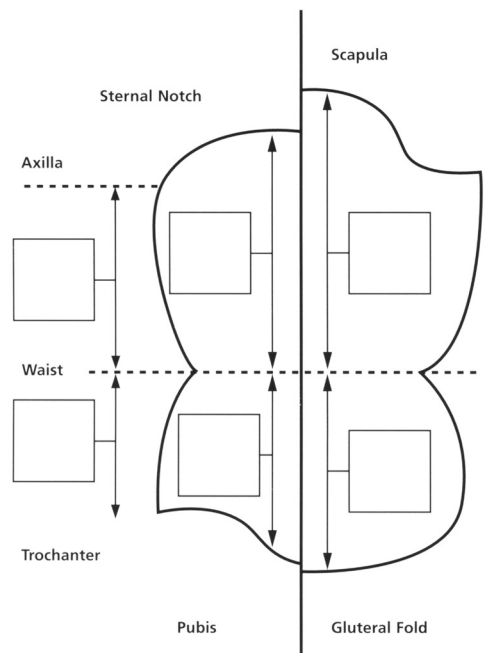
Spinal Brace Prescription Form

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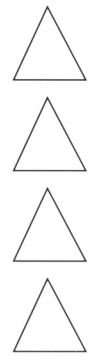


Dimensions
 inches cms mm

Finished Trim

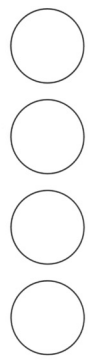


Medial Lateral



Axilla
 Xyphoid
 Waist
 Trochanter

Circumference



Type <small>(Please tick)</small>	<input type="radio"/> TLSO	<input type="radio"/> LSO	<input type="radio"/> High Profile	<input type="radio"/> Low Profile
Opening	<input type="radio"/> Anterior	<input type="radio"/> Lateral		
Lordosis	<input type="radio"/> 0	<input type="radio"/> 10	<input type="radio"/> 15	<input type="radio"/> 20
Abdominal Relief	<input type="radio"/> Slight	<input type="radio"/> Medium	<input type="radio"/> Large	<input type="radio"/> Neutral

Practitioner _____
 Date _____ Date required _____
 P.O. Number _____
 Company Name _____
 Ship to _____
 Telephone _____

Patient's Name _____
 Date of Birth _____
 Gender M / F Which side L / R
 Height _____ cm
 Weight _____ kg
 Diagnosis _____

ADDITIONAL INFORMATION