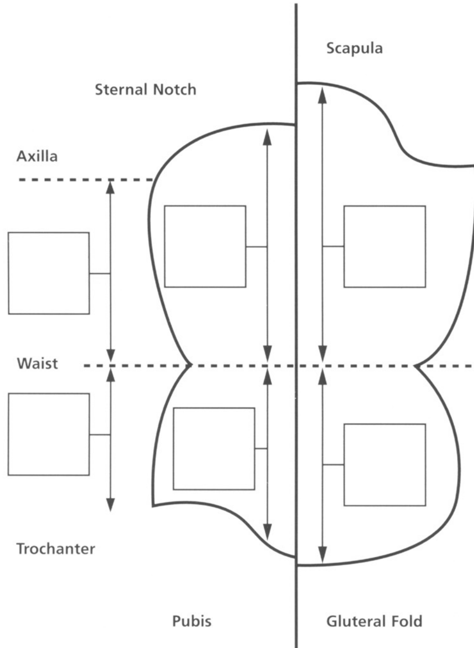
Spinal Brace Prescription Form

Dimensions

☐ inches ☐ cms ☐ mm

Finished Trim



Medial Lateral

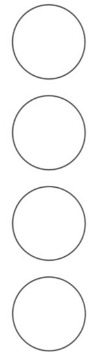
Axilla

Xyphoid

Waist

Trochanter

Circumference



Type *(Please tick)*	◯ TLSO	◯ LSO	◯ High Profile	◯ Low Profile
Opening	◯ Anterior	◯ Lateral		
Lordosis	◯ 0	◯ 10	◯ 15	◯ 20
Abdominal Relief	◯ Slight	◯ Medium	◯ Large	◯ Neutral

Practitioner ______________________

Patient's Name ______________________

Date __________ Date required __________

Date of Birth ______________________

P.O. Number ______________________

Gender ◯ M / F ◯ Which side ◯ L / R ◯

Company Name ______________________

Height __________ cm

Ship to ______________________

Weight __________ kg

Telephone ______________________

Diagnosis ______________________

ADDITIONAL INFORMATION