

PRO-TECH INTL NIGHT TIME SCOLIOSIS MEASUREMENT FORM

CUSTOMER INFORMATION

COMPANY NAME: _____

PO #: _____ ACCOUNT # _____


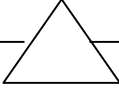
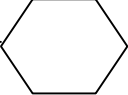

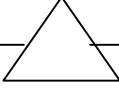
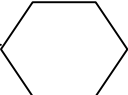

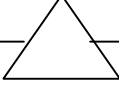
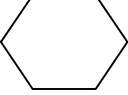


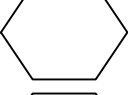

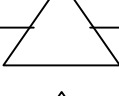
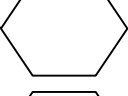



CONTACT PERSON: _____

SHIP TO: _____

PHONE: _____ FAX: _____

REQUESTED DELIVERY DATE: _____

SHIPPING PREFERENCE: _____

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

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

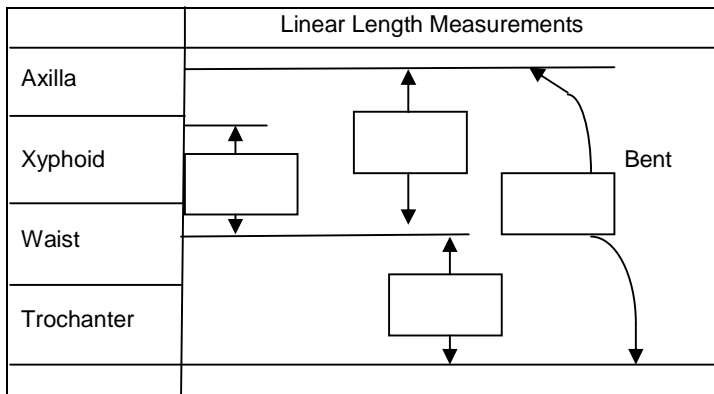
Opening: Anterior

Finished: Yes No

Options: Transfer Paper _____

Torso Sock: Size _____ Quantity _____

Special instructions or remarks: _____



Professional Technologies International, Inc.

104 Otis Street, Suite 27-28 • Northborough, MA 01532

Toll Free Phone: 866-819-1157 • Toll Free Fax: 866-473-8105

Office use only:	
Mold # _____	Modified by _____
Finished by _____	