GOMEZ ORTHOTIC SYSTEMS

SPINAL MEASUREMENT FORM

DATE _____ TAKEN BY _____ ORDER # _____

SHIP VIA _____ REQUESTED DUE DATE _____ PO # _____

ACCOUNT _____ PHONE _____ CONTACT _____

SHIP TO _____

ADDRESS _____ STATE _____ ZIP _____

PATIENT INFORMATION

NAME _____ PHYSICIAN _____

☐ MALE ☐ FEMALE DOB _____ AGE _____ HEIGHT _____ WEIGHT _____

DIAGNOSIS _____ PRESCRIPTION _____

CONTACT _____ PHONE _____

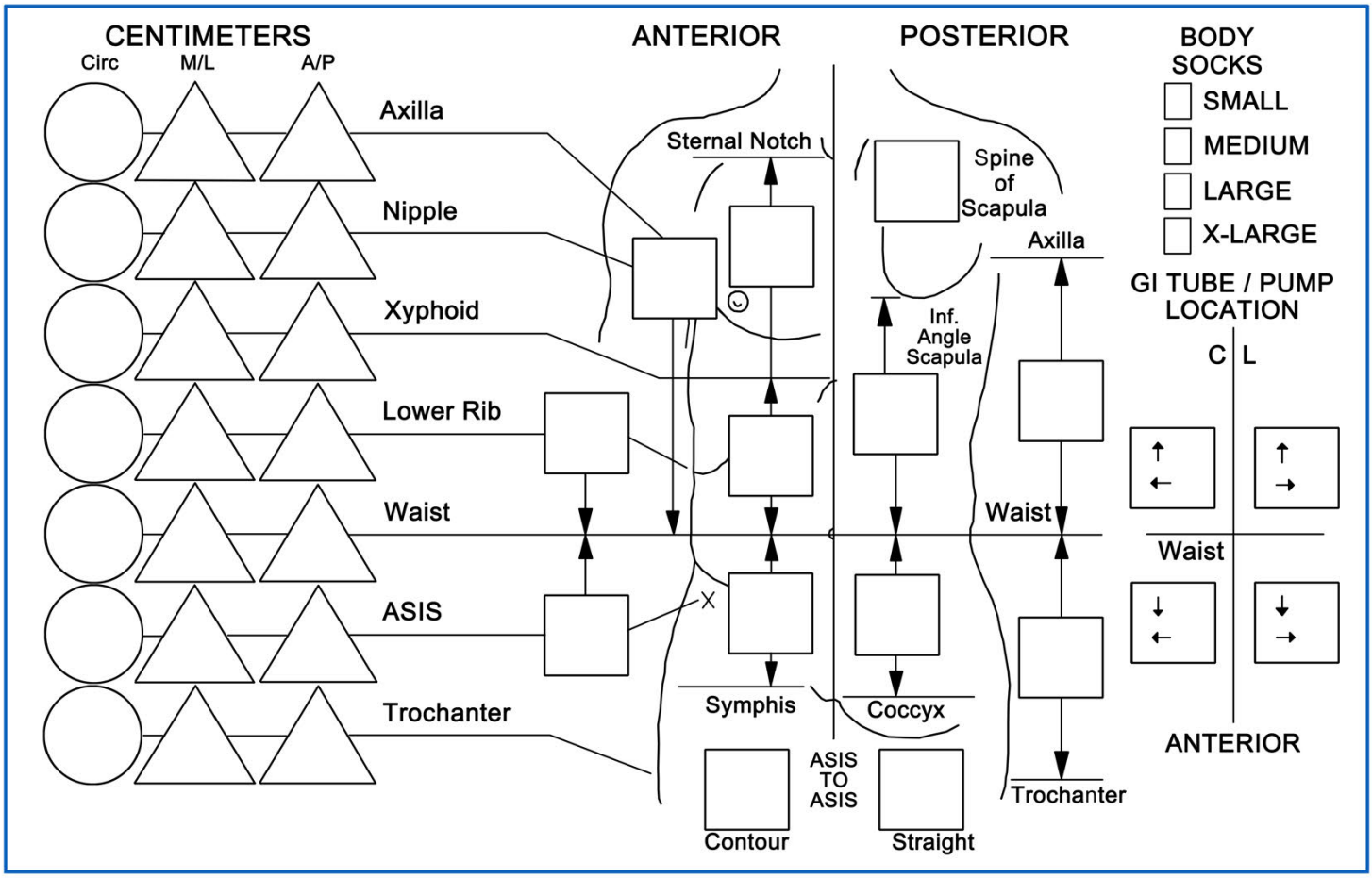
FLEXIBILITY ☐ 0-20% ☐ 20%-40% ☐ 40%-60% ☐ 60%-80% ☐ 80%-100%

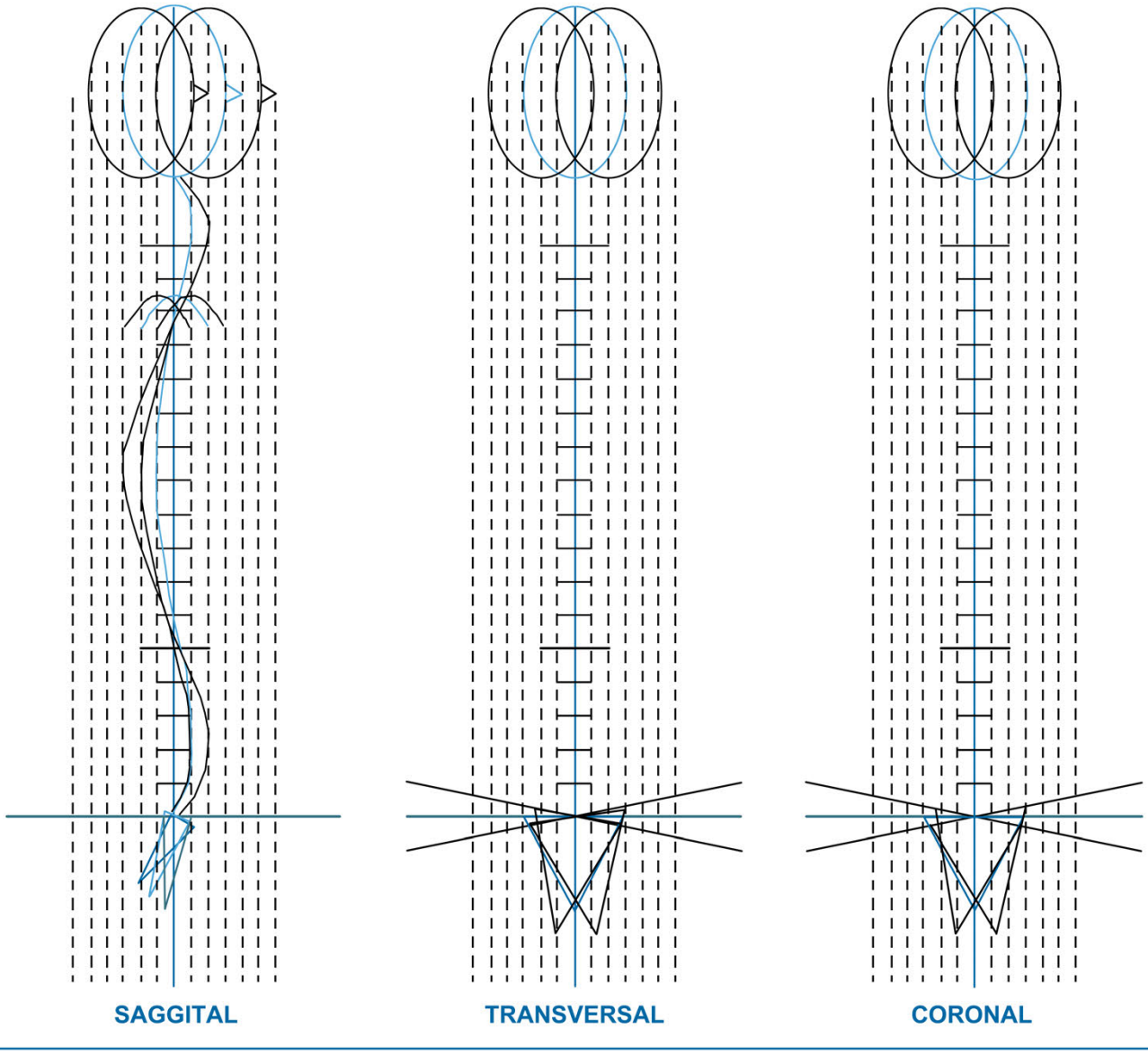
BRACE TYPE ☐ CTLSO ☐ CTO ☐ TLSO ☐ LSO ☐ POSTERIOR SHELL

OPENING ☐ SINGLE ☐ ANTERIOR ☐ POSTERIOR ☐ TONGUE ☐ BI-VALVE

MATERIAL _____ THICKNESS _____ FOAM _____ TRANSFER PAPER _____

NOTES _____





COMMENTS:

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