

MEDICAL



From: _____

Date: ____/____/____

Patient: _____

Date of Birth: ____/____/____

Organization File No _____

Medical Z File No. _____

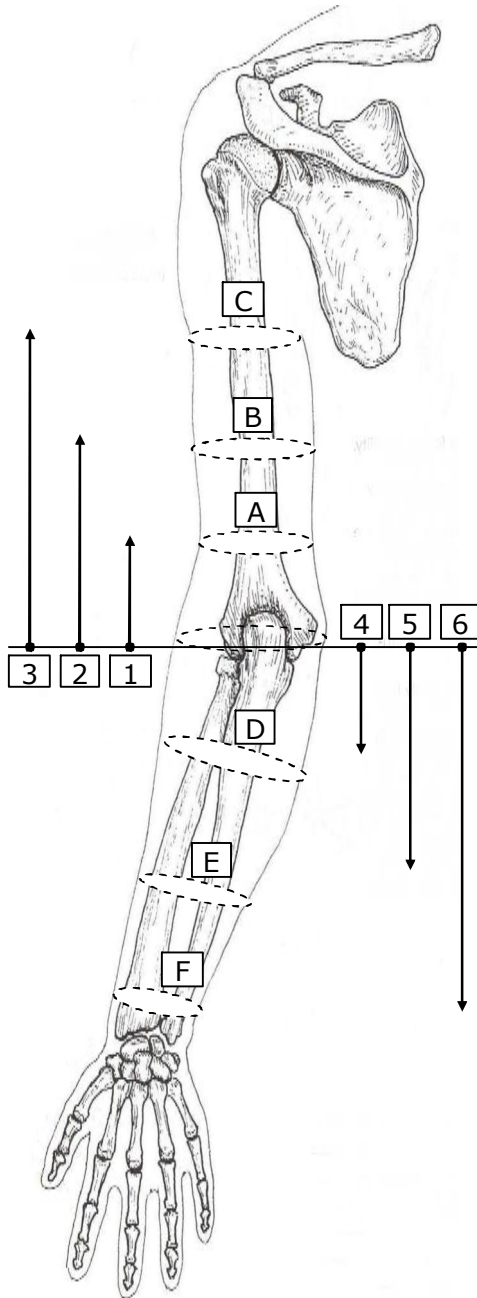
Measured By _____/_____

Comments: _____

Posterior View

Left Arm

	Coolmax
	Reg. Fabric



Right Arm Above Elbow

Lengths		Circum.
1	A	
2	B	
3	C	

Left Arm Above Elbow

Lengths		Circum.
1	A	
2	B	
3	C	

Right Elbow	Circum.		Left Elbow	Circum.	
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(all lengths are taken from Elbow)

Right Arm Below Elbow

Lengths		Circum.
4	D	
5	E	
6	F	

Left Arm Below Elbow

Lengths		Circum.
4	D	
5	E	
6	F	

Options

	Lining
	Padding
	Velcro Tabs
	Quantity
	Color

Styles

	Axilla to Elbow
	Elbow to Wrist
	Axilla to Wrist

Zipper Location

R		L		Lateral (outside)
R		L		Medial (inside)

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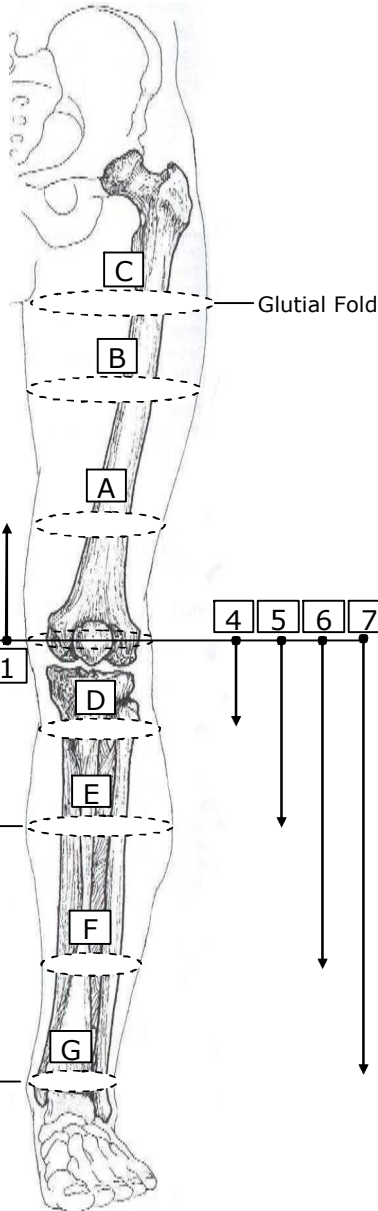
Measured By _____/_____/_____

Comments: _____

Anterior View

Left Leg

Coolmax
Reg. Fabric



Right Leg Above Knee

Lengths		Circum.
1	<input type="text"/>	A <input type="text"/>
2	<input type="text"/>	B <input type="text"/>
3	<input type="text"/>	C <input type="text"/>

Left Leg Above Knee

Lengths		Circum.
1	<input type="text"/>	A <input type="text"/>
2	<input type="text"/>	B <input type="text"/>
3	<input type="text"/>	C <input type="text"/>

Right Knee Circum.

Left Knee Circum.

Knee (all lengths are taken from mid patilla)

Right Leg Below Knee

Lengths		Circum.
4	<input type="text"/>	D <input type="text"/>
5	<input type="text"/>	E <input type="text"/>
6	<input type="text"/>	F <input type="text"/>
7	<input type="text"/>	G <input type="text"/>

Left Leg Below Knee

Lengths		Circum.
4	<input type="text"/>	D <input type="text"/>
5	<input type="text"/>	E <input type="text"/>
6	<input type="text"/>	F <input type="text"/>
7	<input type="text"/>	G <input type="text"/>

Options

<input type="checkbox"/>	Lining
<input type="checkbox"/>	Padding
<input type="checkbox"/>	Velcro Tabs
<input type="checkbox"/>	Quantity
<input type="checkbox"/>	Color

Styles

<input type="checkbox"/>	Thigh Band
<input type="checkbox"/>	Knee to Anke
<input type="checkbox"/>	Thigh to Anke

Zipper Location

R <input type="checkbox"/>	L <input type="checkbox"/>	Lateral (outside)
R <input type="checkbox"/>	L <input type="checkbox"/>	Medial (inside)