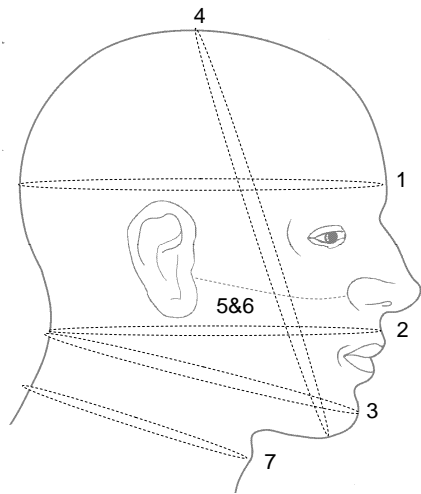




From: _____
 Date: ____/____/____
 Patient: _____
 Date of Birth: ____/____/____
 Organization File No. _____
 Medical Z File No. _____
 Measured By _____ / _____

Comments: _____



<input type="text"/>	Wellness
<input type="text"/>	Coolmax
<input type="text"/>	Reg. Fabric

<input type="text"/>	Color
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Circumferences

<input type="text"/>	1. Above Eyebrows
<input type="text"/>	2. Under Nose
<input type="text"/>	3. Around Chin and Back of Neck
<input type="text"/>	4. Under Chin & Top of Head
<input type="text"/>	5. From Nostril to Left Ear
<input type="text"/>	6. From Nostril to Right Ear
<input type="text"/>	7. Neck Circumference

Lengths

<input type="text"/>	8. Chin to Top of Head
<input type="text"/>	9. Chin to Eyes
<input type="text"/>	10. Chin to Nose
<input type="text"/>	11. Chin to Mouth
<input type="text"/>	12. Width of Eyes
<input type="text"/>	13. Width Bridge of Nose
<input type="text"/>	14. Length of Left Ear
<input type="text"/>	15. Length of Right Ear
<input type="text"/>	16. Width of Nose
<input type="text"/>	17. Width of Mouth
<input type="text"/>	18. Neck Length

Style

<input type="text"/>	Face Mask
<input type="text"/>	Open Face Mask
<input type="text"/>	Chin Strap
<input type="text"/>	Modified Chin Strap
<input type="text"/>	Neck Band
<input type="text"/>	Other

