

COMPANY: _____

ACCOUNT NO.: _____

ADDRESS LINE 1: _____

ADDRESS LINE 2: _____

CITY, STATE, ZIP: _____

PRACTITIONER: _____

PHONE: _____

EMAIL: _____

PURCHASE ORDER: _____

PATIENT ID: _____

PATIENT INFORMATION

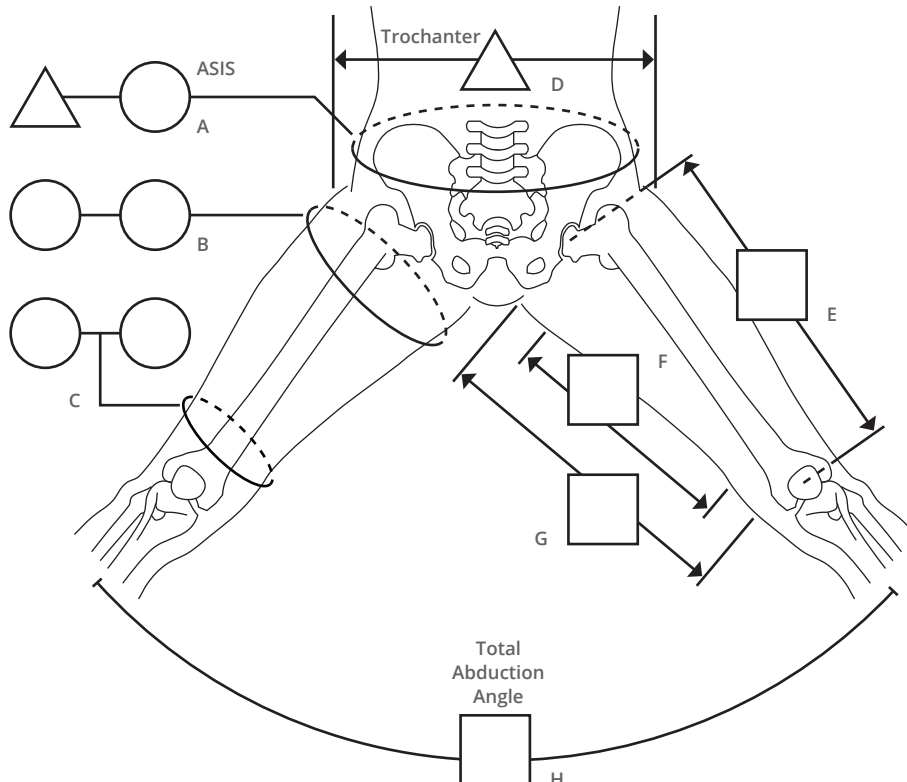
AGE: _____ **WEIGHT:** _____

SEX: _____ **HEIGHT:** _____

PATIENT MEASUREMENTS

Please complete all necessary measurements:

- | | |
|--|--|
| A. Diameter and Circumference taken just below Crests | E. Distance from Center Hip Joint (CHJ) to Center Knee Joint (CKJ) |
| B. Right and Left Circumference taken 2 in. below Perineum | F. Distance 2 in. below Perineum (Prox. Circ. B) to 2 in. above Patella (Distal Circ. C) |
| C. Right and Left Circumference taken 2 in. above Patella | G. Distance from Perineum to Top of Condyle |
| D. Diameter at Trochanters | H. Abduction Angle |



TYPE

- ☐ Scottish Rite Orthosis with Thrust Bearing Hip Joints, No Telescoping Bar
- ☐ Scottish Rite Orthosis with Thrust Bearing Hip Joints with Telescoping Bar
- ☐ Scottish Rite Orthosis with Telescoping Bar
- ☐ Scottish Rite Orthosis for Failed Total Hip Prosthesis or for Post-Surgical Use

DEGREE OF ABDUCTION

Right Side

- ☐ 0° Abduction
- ☐ 10° Abduction
- ☐ 25° Abduction
- ☐ 35° Abduction
- ☐ Variable Abduction Hip Joint

Left Side

- ☐ 0° Abduction
- ☐ 10° Abduction
- ☐ 25° Abduction
- ☐ 35° Abduction
- ☐ Variable Abduction Hip Joint

MOTION CONTROL PLATE

- ☐ Right, set at 0° Extension _____ ° Flexion
- ☐ Left, set at 0° Extension _____ ° Flexion

NOTES
