



Charleston Bending Brace

Orlando Ph 407.852.6170 | Fx 407.852.6171
NationalLabs_Orlando@spsco.com

Workorder #:
(Lab Use Only)

Bill To: _____
Address: _____

Same as Bill to

Ship To: _____
Address: _____

Email: _____
Phone #: _____

Patient Name: _____
Order Date: _____

Height: _____ Pt is a previous CBB wearer Male
Weight: _____ Female
Age: _____ Other Brace Type: _____

io Compliance Monitor (1/4" foam only): YES NO

In-Office Request Date: _____ am pm

CBB-Standard CBB II-Dynamic Lumbar Pad

STANDARD COLORS

(Choose One)

Natural Fridles Transfer (extra charge)
 Light Pink Number: _____
 Light Blue Description: _____

SELECT TYPE OF TREATMENT **OR** **PROVIDE MAJOR CURVE** **BRACE BEND TO**

CBB-1 LT Right
 CBB-2 RT Left
 CBB-3 Double
 CBB-4 Lumbar
 CBB-5 Thoracic
 Thorocolumbar

COBB ANGLES: Thoracic _____ Apex _____
(limits & magnitudes) Lumbar _____ Apex _____

LORDOSIS Supine mx: _____
In brace: 10° 20° Other: _____°
(In brace 0° if not otherwise specified)

Manual: English Spanish

SPECIAL INSTRUCTIONS:

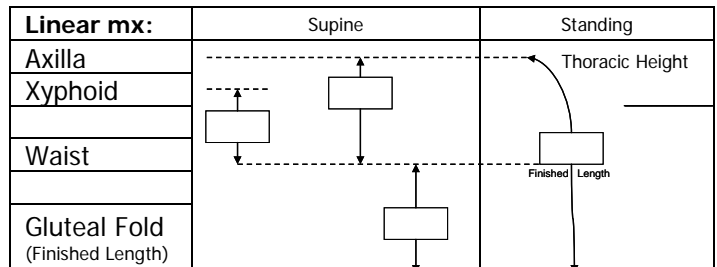
IMPORTANT INSTRUCTIONS

- All measurements must be taken and completed on this order form
- X-rays must be sent or a digital image sent to cfaborlando@spsco.com
In the Subject Line: Charleston Brace for "Patient Name"
- If information is incomplete, your brace cannot be manufactured

MEASUREMENTS IN INCHES ONLY

Measurements taken	Standing	Supine	Supine
	Circ.	M/L *	A/P *
Axilla			
Xyphoid			
2" above waist			
Waist			
ASIS			
Gluteal Fold/ Trochanter			

* M/L & A/P measurements taken with a M/L mx stick (not a tape measure)



(All length measurements will be used to determine finished trims)

Practitioner (print name): _____

Signature: _____
(Must be signed by a CBB Certificate holder only)

CBB Certification Number: _____