



Phone: (888) 330-2289
Fax: (805) 278-6609

Name: _____ Date: _____
Diagnosis: _____
Address: _____ DOB: _____
Phone Number: _____

Please check as indicated:

- | | |
|--|--|
| <input type="checkbox"/> Examination and treatment | <input type="checkbox"/> To facilitate healing post soft tissue or spine injury |
| <input type="checkbox"/> To support weak spinal muscles | <input type="checkbox"/> To facilitate healing post surgical procedure on spine or related soft tissue |
| <input type="checkbox"/> To reduce pain by restricting mobility of the trunk | <input type="checkbox"/> Balance |
| <input type="checkbox"/> To support deformed spine | |

ICD-10 code: _____

Signature: _____

Print Name: _____ Print Title: _____ Date: _____

NPI No. _____

******* Below area for therapist completion *******

- | | |
|--|--|
| <input type="checkbox"/> OW200 BalanceWear® Custom LSO | <input type="checkbox"/> BW450 BalanceWear® Breeze™ |
| <input type="checkbox"/> BW300 BalanceWear® Classic | <input type="checkbox"/> OW226 BalanceWear® Lumbar Support 6 |
| <input type="checkbox"/> BW350 BalanceWear® LightWeight™ | <input type="checkbox"/> OW228 BalanceWear® Lumbar Support 8 |
| <input type="checkbox"/> BW400 BalanceWear® EasyWear™ | <input type="checkbox"/> BW430 BalanceWear® Baseball Hat |

Num. Weights Needed:

1/2 lbs. _____
1/4 lbs. _____
1/8 lbs. _____
1/16 lbs. _____

Patient Measurements:

Waist: _____
Height: Front: _____ Back: _____
Hat: Adult _____ Youth _____

Measure

Waist: measure around waist at thickest part

Height Front: measure from top of shoulder down body to bottom front of vest.

Height Back: measure from top of shoulder down body to bottom back of vest.

Referring Therapist (Please print name): _____

Phone Number: _____