

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

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: _____
 Physician Signature: _____
 National Provider Number: _____

BalanceWear®-Trained Clinician Fills Out Below

- | | |
|---|---|
| <input type="checkbox"/> OW200/250 BalanceWear Custom LSO | <input type="checkbox"/> BW450 BalanceWear Breeze™ |
| <input type="checkbox"/> BW350 BalanceWear LightWeight™ | <input type="checkbox"/> OW226 BalanceWear® Lumbar Support 6" |
| | <input type="checkbox"/> OW228 BalanceWear® Lumbar Support 8" |

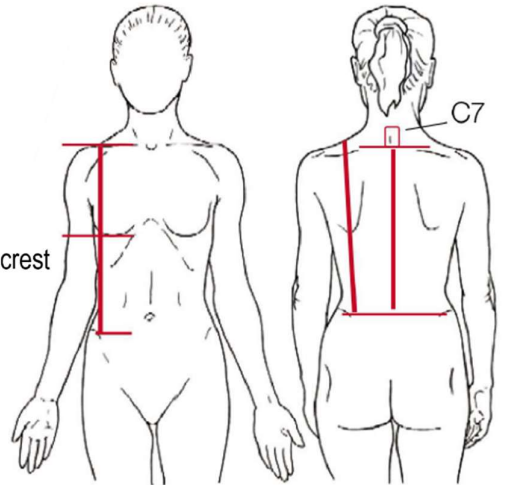
Note: If this order is an OW200/250, please send to a local orthotist. Fax Number: _____

Weights Needed: 1/2 # _____ 1/4 # 2x2 _____ 1/8 # 2x1 _____ 1/16 # _____
 1/4 # 2x4 _____ 1/8 # 2x2 _____

Weight Placement

G. Draw the Final Weight amount and placement on the body diagram

- Measure from top of shoulder to bottom of breast
- Measure from top of shoulder to 1 inch below waist or to iliac crest
- Measure from top of shoulder to Lumbo sacral junction
- Measure from C7 to L5S1
- Girth – thickest point near waist/ iliac crest



Clinician Signature: _____
 Clinician Name: _____ Phone #: _____