

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 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" |

**Weights Needed:** 1/2 # \_\_\_\_\_ 1/4 # \_\_\_\_\_ 1/8 # \_\_\_\_\_ 1/16 # \_\_\_\_\_

**Weight Placement**

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

- |                      |  |
|----------------------|--|
| <input type="text"/> | Measure from top of shoulder to bottom of breast   |
| <input type="text"/> | Measure from top of shoulder to 1 inch below waist |
| <input type="text"/> | Measure from top of shoulder to L5S                |
| <input type="text"/> | Measure from C7 to L5S1                            |
| <input type="text"/> | Girth - thickest point near waist                  |

