CUSTOM HALO VEST ORDER FORM

For Use With Ossur Halo Traction Systems

PATIENT INFORMATION:

Name: _____

Height: _____

Weight: _____

Sex: _____

Age: _____

Kyphotic: ☐ YES ☐ NO

Description of anatomical anomaly(ies):

- ☐ Pendulous abdomen (indicate on drawing)
- ☐ Large breasts (indicate on drawing)
- ☐ Bony Prominences (indicate on drawing)
- ☐ Other: _____

FACILITY INFORMATION:

Practitioner Name: _____

P.O.#: _____

Facility/Hospital Name: _____

Order Date: _____

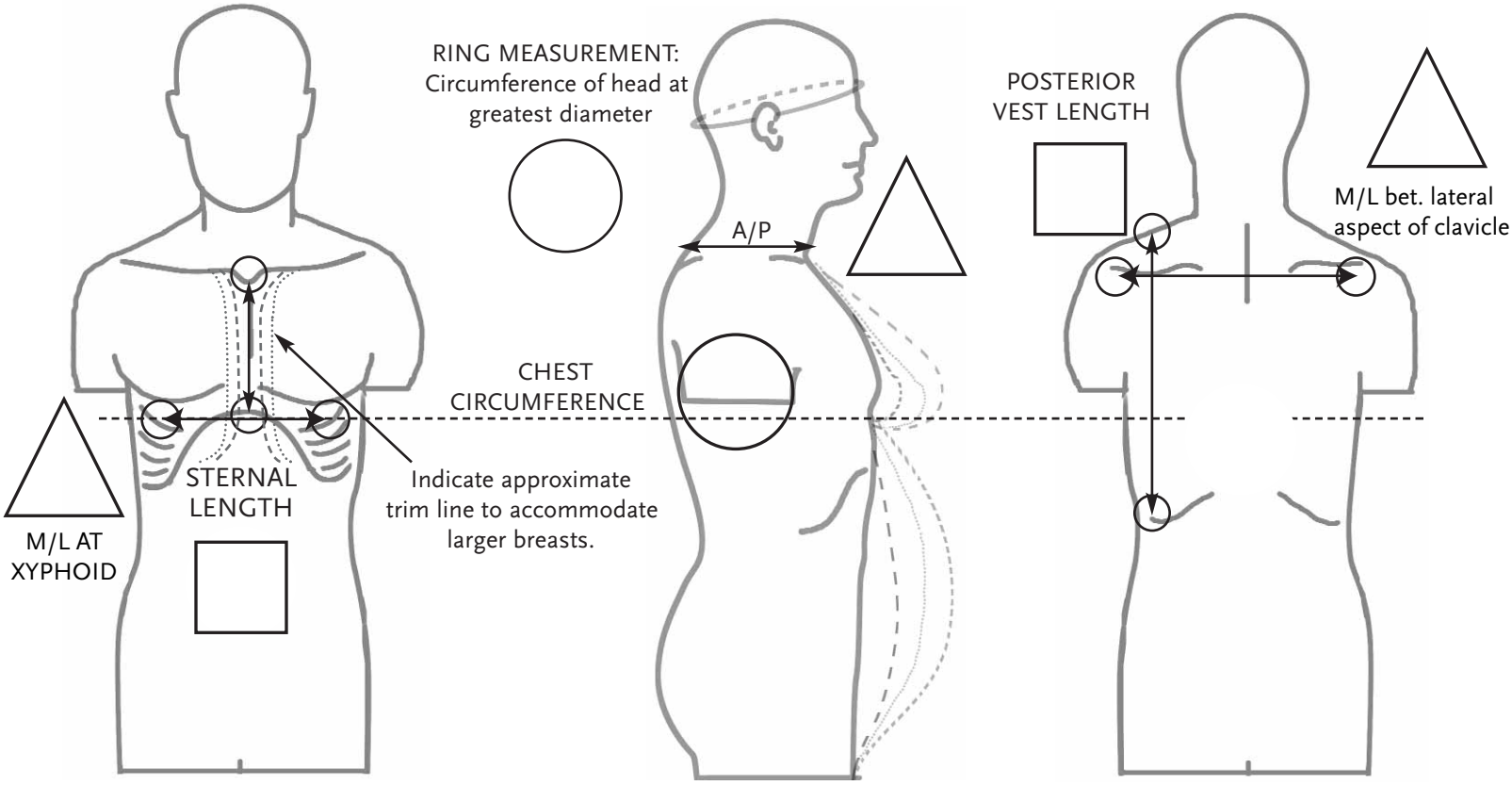
Due Date: _____

Requested Turnaround: _____

Shipping Requirements: _____

Customer Account Number:

Measurements taken: ☐ STANDING ☐ SUPINE Write appropriate measurements below.



Any pre-existing injury that may interfere with halo application? ☐ YES ☐ NO

Please describe below & indicate location on above diagrams. If available, please also attach photo/digital image. _____

_____

_____

www.ossur.com

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Life Without Limitations®

CUSTOM PEDIATRIC HALO VEST ORDER FORM

For Use With Ossur Halo Traction Systems

PATIENT INFORMATION:

Name: _____

Height: _____

Weight: _____

Sex: _____

Age: _____

Kyphotic: ☐ YES ☐ NO

Description of anatomical anomaly(ies):

☐ Bony Prominences (indicate on drawing)

☐ Other: _____

FACILITY INFORMATION:

Practitioner Name: _____

P.O.#: _____

Facility/Hospital Name: _____

Order Date: _____

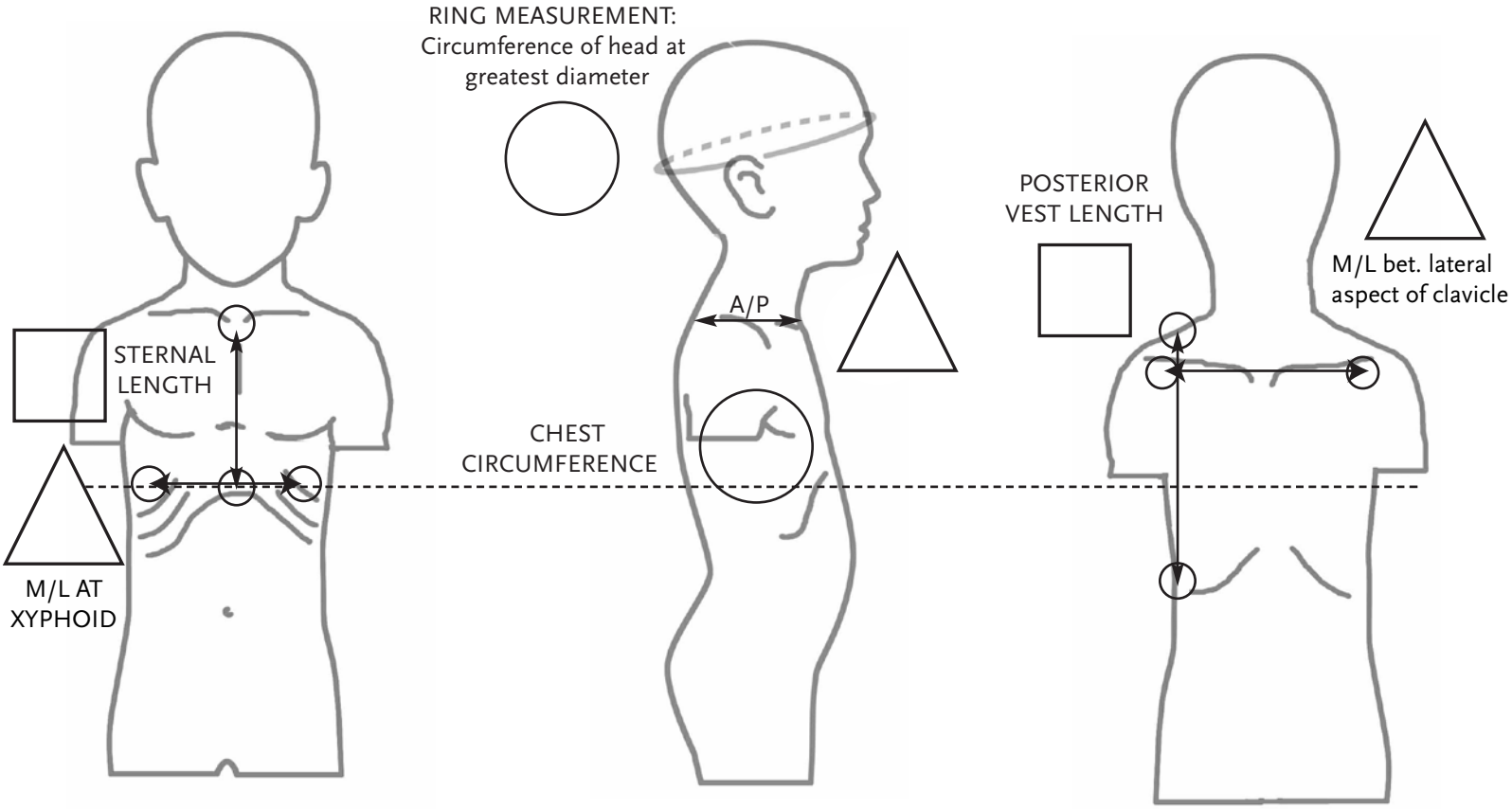
Due Date: _____

Requested Turnaround: _____

Shipping Requirements: _____

Customer Account Number:

Measurements taken: ☐ STANDING ☐ SUPINE Write appropriate measurements below.



Any pre-existing injury that may interfere with halo application? ☐ YES ☐ NO

Please describe below & indicate location on above diagrams. If available, please also attach photo/digital image. _____

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