BECKER
A Tradition of Excellence A Commitment to Innovation

Cranial Remolding Orthosis Order Form

Note: A completed order form is required before the order can be processed.

ORTHOTIST INFORMATION

Facility Name: ______________________ **Orthotist Name:** ______________________
Shipping Address: ______________________ P.O. #: ______________________
______________________ Date Requested: ______________________
______________________ Phone: ______________________
City: __________ State: ___ Zip: _____ Fax: ______________________

- *Turnaround time is 4 business days from receipt of scan **and** completed order form.*
- *For best results, the patient should be fit within two weeks from the date of the scan/cast.*

PATIENT INFORMATION

Patient Name: ______________ **Date of Birth:** __________ **Date of Scan/Cast**: __________
Diagnosis: ☐ Plagiocephaly ☐ Brachycephaly ☐ Other______________

SCAN/CAST INFORMATION

Required Landmarks: *Outline of ears, brow line marked on both temples, center of nose marked on forehead*

Scan Impression: ☐ Unmodified Scan/Cast ☐ Modified Scan/Cast
Description of Cranial Form (please indicate all applicable conditions):

FLATTENING

	Left	Bilateral	Right	N/A
Occipital Area	☐	☐	☐	☐
Parietal Area	☐	☐	☐	☐

DESCRIPTION OF DEFORMITY

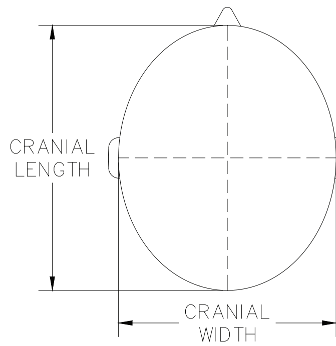
	Left	Right	Posterior	N/A
Ear – Anterior Shift	☐	☐		☐
Frontal Bossing	☐	☐		☐
Elevated Cranial Height	☐	☐	☐	☐

Please completely fill out the order form including all required measurements and information.

REQUIRED MEASUREMENTS

Take measurements at a level just above the top of the ears and the brow line over stockinette.
Order will not be processed without required measurements.

ORTHOTIST
Circumference: _____cm
Cranial Length: _____cm
Cranial Width: _____ cm



FOR INTERNAL USE ONLY

UNMODIFIED MOLD
Circumference: _____cm
Cranial Length: _____cm
Cranial Width: _____cm

MODIFIED MOLD
Circumference: _____cm
Cranial Length: _____cm
Cranial Width: _____cm

Build-up added
Right Anterior ☐
Left Anterior ☐
Right Posterior ☐
Left Posterior ☐

ORTHOSIS INFORMATION

Side Opening: ☐ Left ☐ Right
Attach Chafe: ☐ Anterior to slot ☐ Posterior to slot ☐ Send – do not attach
Transfer Paper Design: ________________________________
Positive Image Transfer: ________________________________

☐ Copolymer Shell

Liner Thickness & Density
☐ ¼ Medium ☐ ¼ Soft
☐ ½ Medium ☐ ½ Soft

SPECIAL INSTRUCTIONS

____
____
____

SHIPPING INSTRUCTIONS

☐ UPS Ground ☐ UPS 2ND Day Air ☐ UPS Next Day Air ☐ Other: ______________________

FOR INTERNAL USE

Order Number: __________________________ Approved By: _______________________

Please completely fill out the order form including all required measurements and information.

 Becker Orthopedic • 635 Executive Drive • Troy, MI 48083 Phone 248-588-7480 • Fax 248-588-4555