Motion Therapeutics

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

Please check as indicated:

- ☐ Examination and treatment
- ☐ To support weak spinal muscles
- ☐ To reduce pain by restricting mobility of the trunk
- ☐ To support deformed spine
- ☐ To facilitate healing post soft tissue or spine injury
- ☐ To facilitate healing post-surgical Procedure on spine or related soft tissue
- ☐ Balance

ICD-10 code: _____
Physician Signature: _____
National Provider Number: _____

BalanceWear®-Trained Clinician Fills Out Below

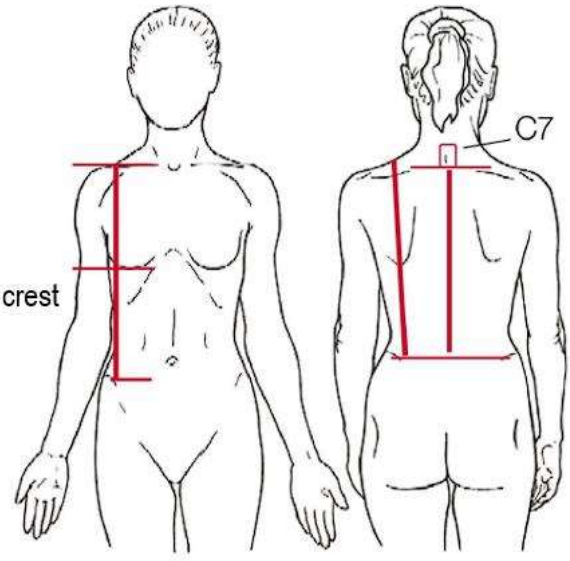
- ☐ OW200/250 BalanceWear Custom LSO
- ☐ BW350 BalanceWear LightWeight™
- ☐ BW450 BalanceWear Breeze™
- ☐ OW226 BalanceWear® Lumbar Support 6”
- ☐ OW228 BalanceWear® Lumbar Support 8”

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



inches	Measure from top of shoulder to bottom of breast
inches	Measure from top of shoulder to 1 inch below waist or to iliac crest
inches	Measure from top of shoulder to Lumbo sacral junction
inches	Measure from C7 to L5S1
inches	Circumference at the thickest area waist/pelvis

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

Motion Therapeutics Inc., | Phone: (888)330-2289 | Fax: (510)254-3371 | Email: cindy@motiontherapeutics.com