Inpatient spinal bracing request

This form has been created to help coordinate and expedite orthotic treatment as part of the care pathway.

Patient Name		PHN			
Date of Birth		Height		Weight	
Phone No.		Email			
Parent / Guardian Contact Name		Is funding in place?	☐ Yes ☐ No		

Patient Ward / Room		Ward Phone No.	

Physician		
Diagnosis		
Prescribed brace		
Level of injury		
Comorbidities		
Surgical Date		
Pre-Operative Fit Requested	☐ Yes ☐ No	
Wear time protocol	☐ **Full-time**	☐ **Not needed in shower**
	☐ **Upright**	**Other requests:**
Post fit mobilization orders	☐ **Standard: 1.** fit/don, **2.** sit-up/stand to check fit, **3.** x-ray to confirm mobilization	
	☐ **Other:**	
Other Comments		

Note: Please attach Rx to complement request.

COQUITLAM
T 604.520.7332 | F 604.521.7300
Unit 113 – 250 Schoolhouse Street
Coquitlam, BC V3K 6V7

SURREY
T 604.597.4784 | F 604.597.3902
Unit 118 – 12414 82 Avenue
Surrey, BC V3W 3E9

hodgsongroup.ca