

	Patient Last Name:	Patient First Name:
llina	Fitter Last Name:	Fitter First Name:
MEDICAL INC.	Fitter Title:	(example PT/OT/PTA)
	Date:	
	LEGASSIST - LOBULE COMPI	DESSIONI SVETEM (I CS)
BiaCare	Measure & C	
	Micasure & C	Studi i dilli
I have watched the online	e instruction I have read and ι	understand the written measuring Photos have been emailed to:
video for the LegAssist™ o	custom garment. instructions for the	ne LegAssist <sup>™</sup> custom garment. Sales@BiaCare.com
orders will not be accepte	ed without all three boxes being che	ecked. Your assistance in this will help the patient receive a
etter product in less time	e.	
2		
PRODUCT OPTIONS		
<u>.EG:</u>	FOAM: Regular (flat foam)	Advanced (WaveFoam™) OPTIONAL: ☐ Hip Attachmen
		(additional charge)
Follow contour of limb of		
(All measurm	ents in cm)	
Lateral Length	_ <b>A</b> 1	
Medial	<ul> <li>= Locations measured along</li> </ul>	g lateral aspect Waist <b>G</b>
Length ———	B1 Circumference	11 _
Posterior	_	·
Length	_ <b>C1</b> Gluteal Fold	$A_1$
Anterior	D	30 cm -
Length	_ D1	
		20 cm <b>D</b> 1
		15 cm
		10 cm
		5 cm
Lateral Length	<b>A</b> 2 Pick a zero point*	_ Ø Point
_		$-$ 5 cm $ C_2$ $B_2$
Medial Length ————	_ <b>B</b> <sub>2</sub>	10 cm
_	Bottom of Garment*	_ A2
Posterior Length	_ C2 *See instructions	(\\ <sub>E</sub> \\; // \
Anterior	_	\ \\\[\\!\]\\
Length	$\mathbf{D}_{2}$	\ \ \rightarrow \ \ \ \rightarrow \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	Non-order 1666-	Approximatley 8-10cm
	Note: order a LCS Super if greatest circumference is > 90 o	cm from bottom of lobule
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		/ / lobdieI