

TributeNight™ Arm Order Form

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____
 Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style Right Arm _____ Left Arm _____ UE - _____
Channeling Chevron _____ Vertical (Design consult needed) _____
Profile Original _____ Low _____
Color Black _____ Blue _____ Purple _____ Raspberry _____ Slate _____

Modifications

QTY.	Notes/Placement Instruction
___ Zippers
___ Closure (VELCRO® brand)
___ Adjustable panels (VELCRO® brand)
___ Pull-up loops
___ Digit spacers
___ Snap tape

Accessories

- ___ Variable Compression Jacket (VCJ)
- ___ Outer Jacket (OJ)
 - Color: Black _____ Blue _____ Purple _____ Raspberry _____ Slate _____
 - Fastener type: VELCRO® brand fastener _____ Snap _____
- ___ Easy Slide Donning Aid

Special Instructions: _____

Exact Reorder of Order #: _____

4 Billing Information

Quote Only

Business Name: _____
 Phone: _____ Fax: _____
 Contact Name & Phone: _____
 Account #: _____ P.O. #: _____
 Payment: Credit card (provide number below) _____ Net 30 _____
 Card #: _____ Exp: ____/____/____ SID: _____

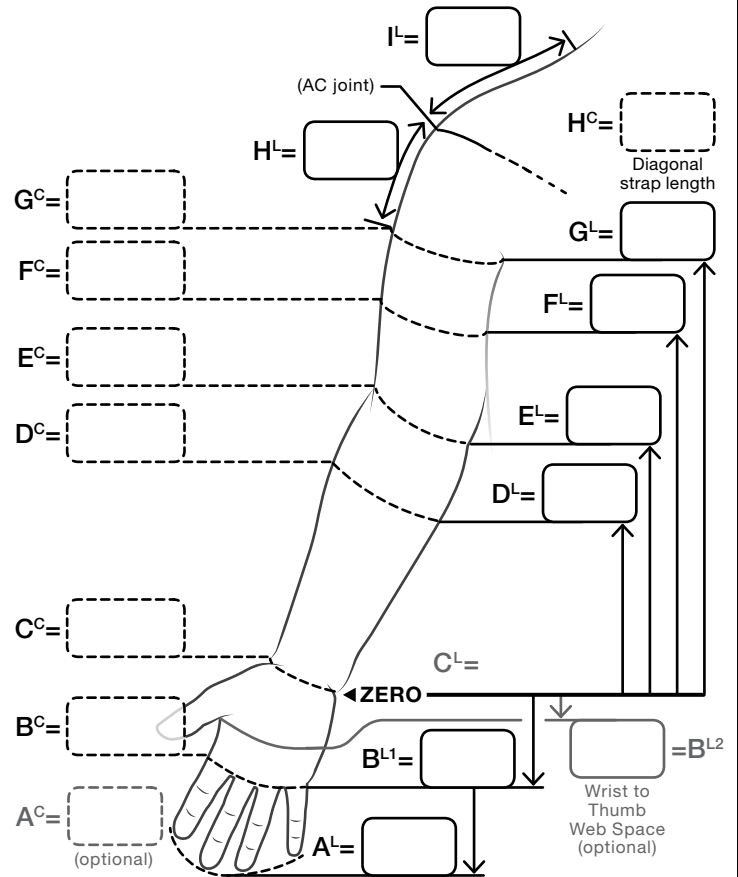
3 Measurements

Date taken: ____/____/____

(All measurements in centimeters)

C = Circumference

L = Length



5 Shipping Information

Shipping: Standard _____
 Priority Requested Delivery Date: _____
 Ship to: _____
 Attn: _____
 Street: _____
 City: _____ State: _____ Zip: _____
 Province: _____ Postal Code: _____
 Phone: _____
 Email (for shipping notification): _____