



Standard UE (Upper Extremity) Measuring Form

PO#: _____ Company: _____ Date: _____

Contact Name: _____ Phone: _____

Bill-To Address: _____

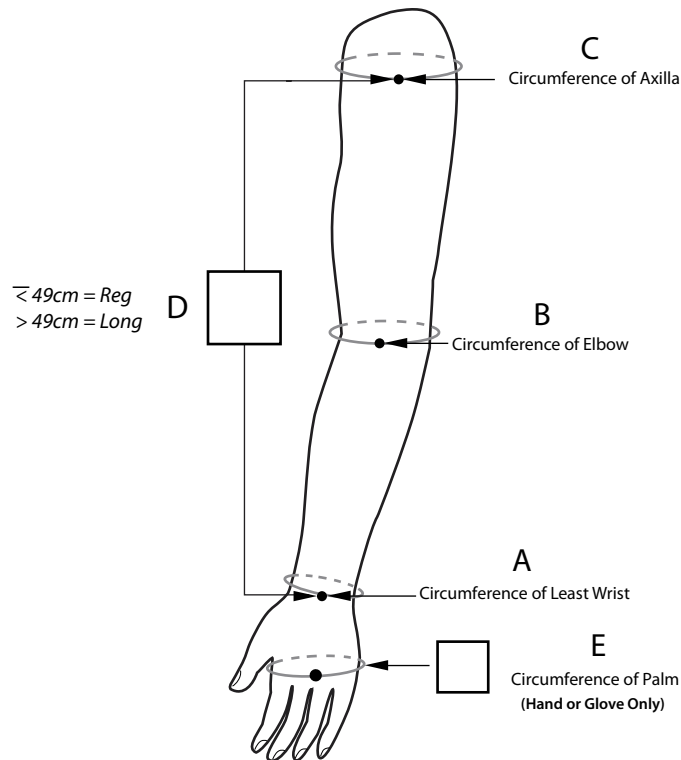
Ship-To Address: _____

Patient: _____ Sex: _____ Age: _____ Ht: _____ Wt: _____

<input type="checkbox"/> CompreSleeve™	<input type="checkbox"/> FoamSleeve™	<input type="checkbox"/> MedaFit™ Sleeve	<input type="checkbox"/> Hand (included)
<input type="checkbox"/> Hand (ONLY)	<input type="checkbox"/> Glove (ONLY)		<input type="checkbox"/> Glove (additional cost)
			<input type="checkbox"/> CD (Sleeve) ONLY

<input type="checkbox"/> Right	<input type="checkbox"/> Left
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(Upper Extremity)



revised: 8.06.08