TO ORDER:

JOBST® JoViPak

Shoulder-Torso Arm Sleeves
Custom

Patient Name:_____

PAYMENT INFORMATION			
Account # (Required)	☐ Bill to Account	Date	
☐ Charge Credit Card	☐☐ Card Exp. Date	PO #	
Card #		Fax Confirmation #	
Name on Card		Email Confirmation	

BILLING ADDRESS		SHIPPING ADDRESS ☐ Same as Billing Address	
Business Name		Name	
Attention		Attention	
Address		Address	
City	State	City	State
Phone	Zip	Phone	Zip

ORDER SPECIFICATIONS

☐ Quote ☐ Order

FREE STANDARD SHIPPING

Two Piece Arm Sleeve with optional Bilateral Arms, Padded Torso, Arm Sling & Dorsum Zipper
(This option is an additional charge)

Optional Padded Torso & One Piece Arm Sleeve
(This option is an additional charge)

Unpadded torso with One Piece Arm Sleeve & recommended JoViJacket
(JoViJacket is an additional charge)

Polartec® Power Dry® Colors	QTY		QTY
☐ Black		☐ Buff	
☐ Pink		☐ Plum	
☐ Royal Blue			

JoViJacket - Nylon & Spandex Powernet	QTY		QTY
☐ Black		☐ White	

(JoViJackets are required to be worn with your JoVi foam garment to ensure maximum fit and effectiveness.)

Comments:

Fitter/Therapist Name: _____ Phone: _____ Email: _____

All sales are subject to JoViPak's Return, Guarantee and Warranty policies

BSN Medical Inc., an Essity company
5825 Carnegie Blvd., Charlotte, NC 28209-4633

JOBST®
JoViPak

Shoulder-Torso Arm Sleeves
Custom

Patient Name:_____ Previous Patient? ☐ Yes Gender: ☐ F ☐ M

Height*:_____ Weight*:_____ Birthdate: _____

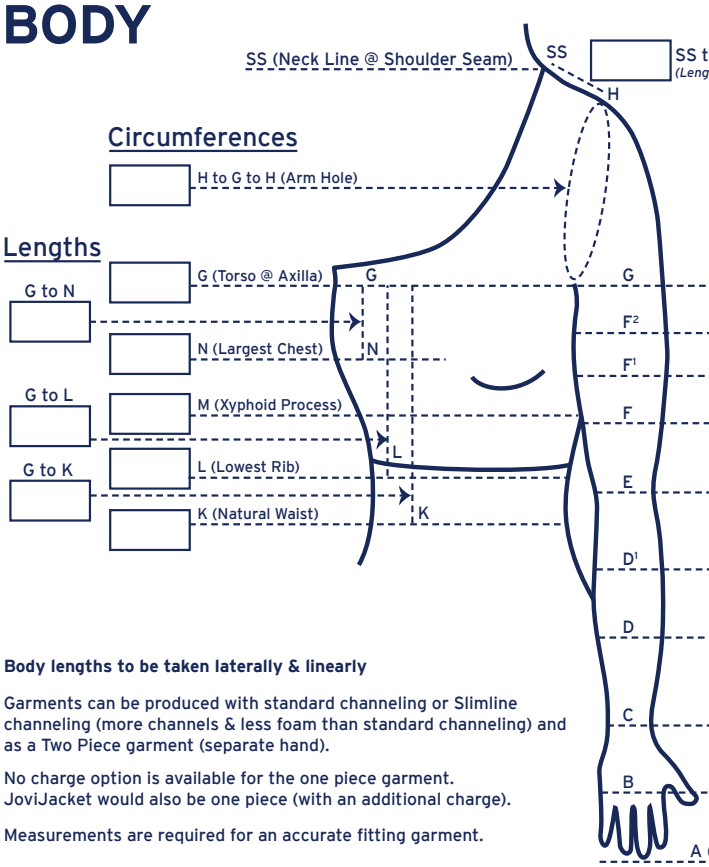
*Height and weight are required.

Must select one: **Mastectomy** ☐ Left ☐ Right **Reconstruction** ☐ Left ☐ Right **Lumpectomy** ☐ Left ☐ Right

Directions: Follow the dotted lines for measurement guidelines.

Please record all measurements in centimeters
All measurements are required

BODY



SS to H (REQUIRED)
(Length: Neck Line to Tip of Acromion Process)

Body lengths to be taken laterally & linearly

Garments can be produced with standard channeling or Slimline channeling (more channels & less foam than standard channeling) and as a Two Piece garment (separate hand).

No charge option is available for the one piece garment. JoviJacket would also be one piece (with an additional charge).

Measurements are required for an accurate fitting garment.

ARM

	Circumferences Left	Circumferences Right		Lengths (Measured medially)	
G			G (Axilla)	C to G	
F²			F² (Upper Bicep)	C to F²	
F¹			F¹ (Mid Bicep)	C to F¹	
F			F (Widest Bicep)	C to F	
E			E (Least Elbow)	C to E	
D¹			D¹ (Widest Forearm)	C to D¹	
D			D (Distal Forearm)	C to D	
C			C (Least Wrist)		
B			B (Palm @ Web Space) *(Do not include thumb)*	C to B	
A (Tip of Longest Finger) *(Required)*				C to A	

No Charge Options

☐ 1 piece Arm Sleeve, glove attached (JoViJacket will also be One Piece)	☐ 2 Blend Foam (Low ILD)

Additional Charge Options

Torso Padding (must select one): ☐ Horizontal Channels ☐ Vertical Channels ☐ No padding (no charge)		Padded Insert (equalizes pressure over mastectomy site) Color: ☐ Black ☐ Buff Size: ☐ Small (A/B) ☐ Large (D) ☐ Medium (C) ☐ XLarge (DD/E)
☐ Stitched Finger Glove		
Pad (sewn in) ☐ Dorsum ☐ Palm		
Zipper ☐ Dorsum to mid-forearm ☐ Wrist to elbow		☐ Arion Easy Slide (for garment without Stitched Finger Glove)
Arm Sling ☐ Garment ☐ JoViJacket	☐ Dycem®	☐ Prepaid Reduction

Fitter/Therapist Name: _____ Phone: _____ Email: _____

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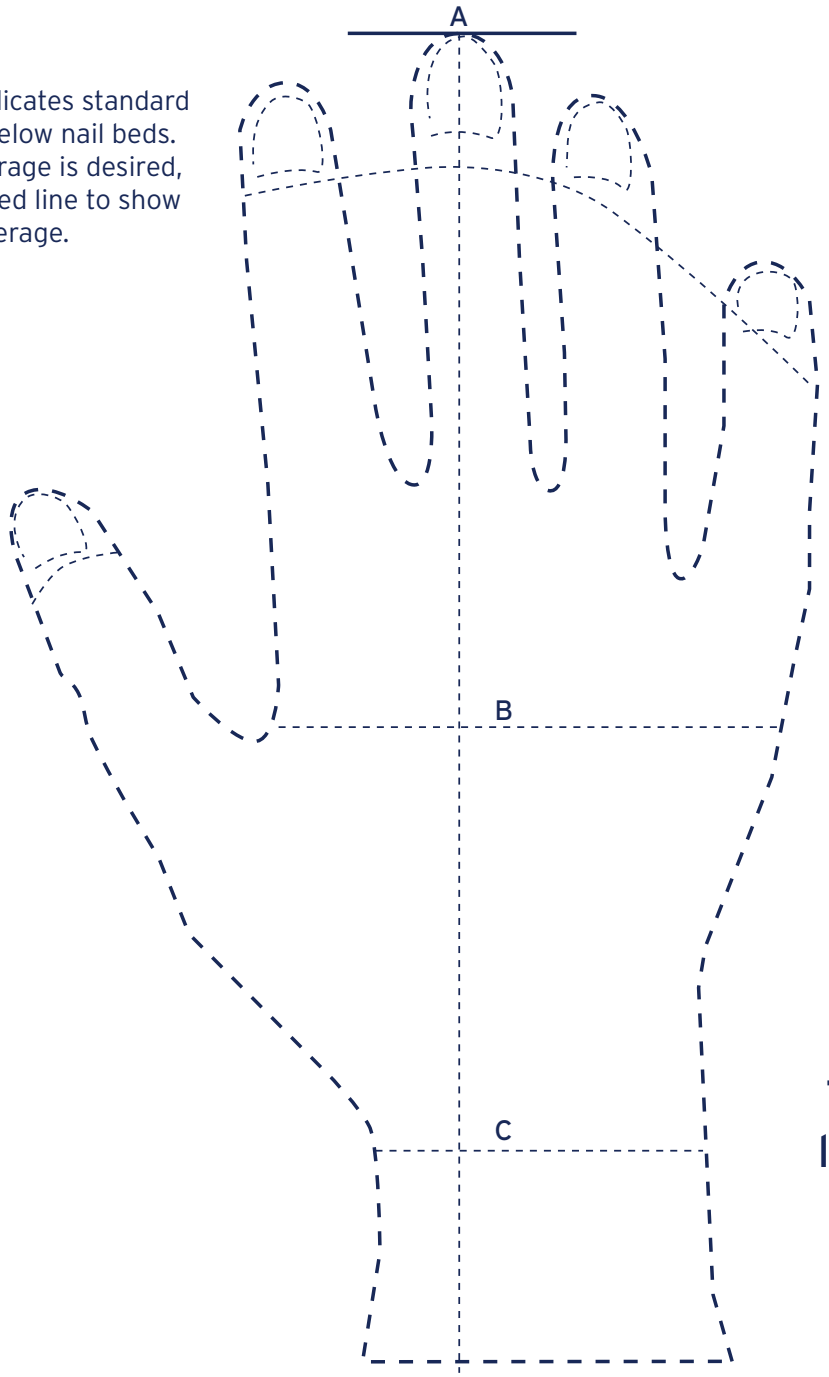
CUSTOM HAND TRACING
RIGHT HAND

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark.
Use a black pen to trace around the hand and each finger.

The dotted line indicates standard hand coverage. Below nail beds. If a different coverage is desired, sketch a new dotted line to show that coverage.



Total hand length (AC)
_____cm

Patient Name or Reference #:_____

JOBST
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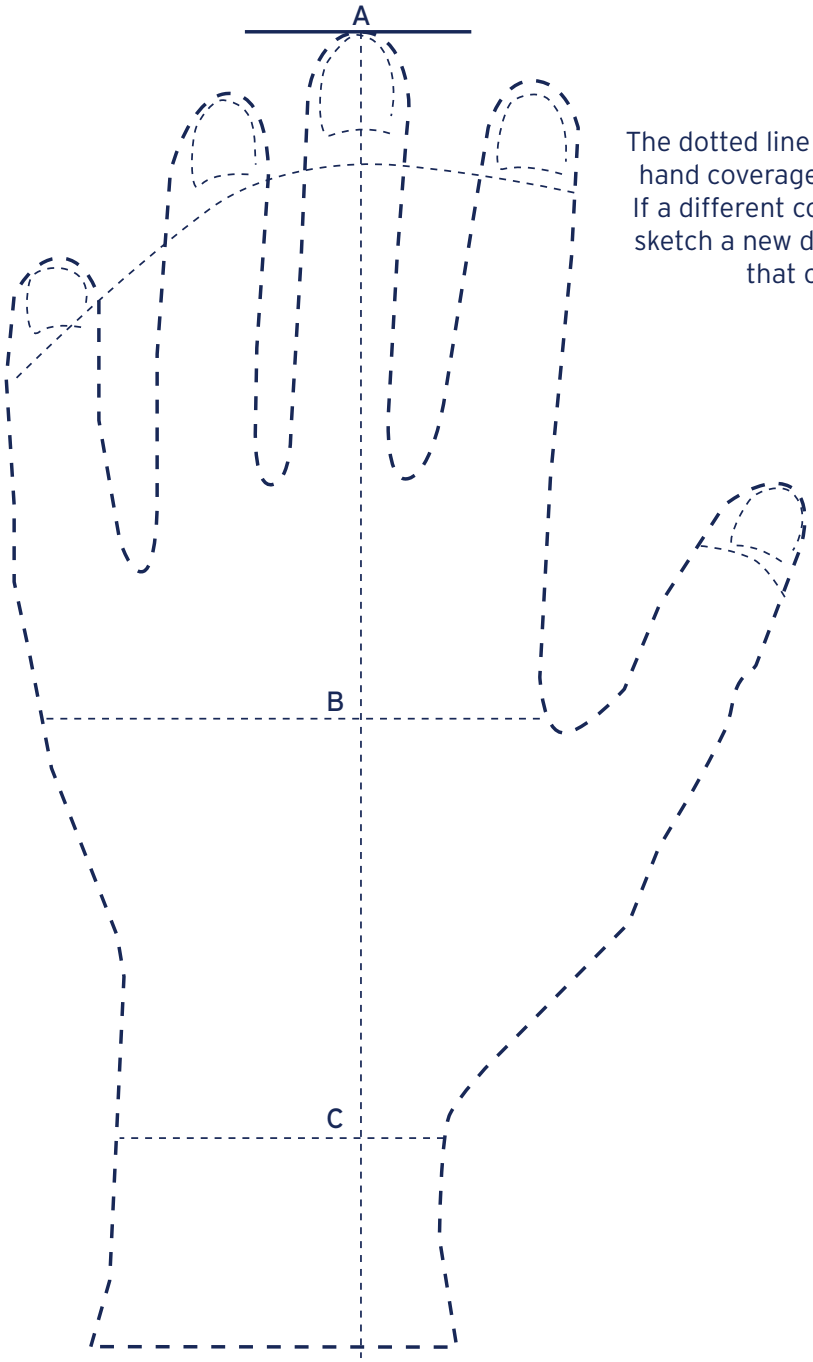
CUSTOM HAND TRACING LEFT HAND

Place hand flat, directly over this guide, palm down, with wrist flexion crease over the C landmark.
Use a black pen to trace around the hand and each finger.



The dotted line indicates standard hand coverage. Below nail beds. If a different coverage is desired, sketch a new dotted line to show that coverage.

Total hand length (AC) _____cm

Patient Name or Reference #:_____