Fabrication Limited
Upper Extremity Fabrication

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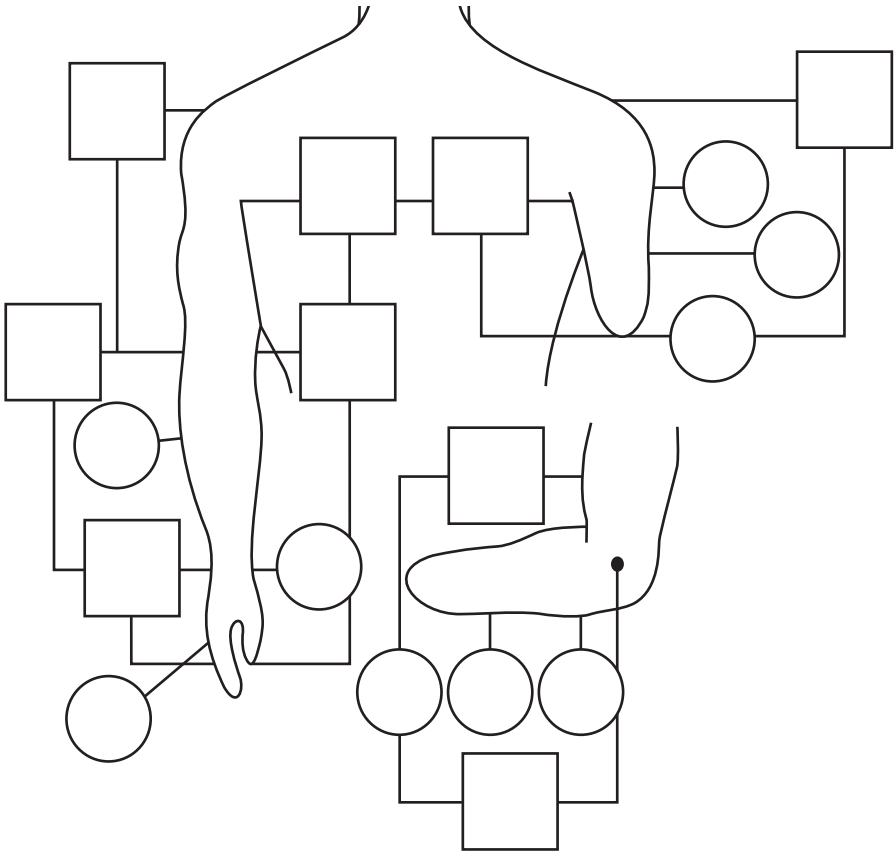
UPPER EXTREMITY MEASUREMENT FORM

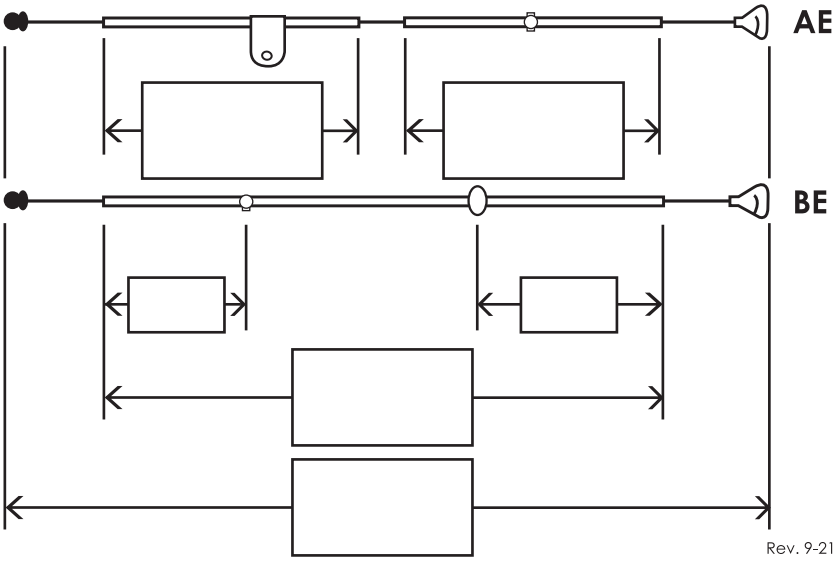
Date In:	Date Due:
P.O.#:	
Practitioner Name:	
Contact Information:	
Company Name:	
Company Address:	
Company Phone:	
Patient Name:	
Weight:	Height:
☐ Left ☐ Right	☐ Male ☐ Female
☐ Caucasian ☐ African American Other: _____	
Amputation Level: ☐ AE ☐ BE ☐ SD ☐ Conventional ☐ Myo Electric	
Check all that apply: ☐ Harness ☐ 1 Cable ☐ 2 Cables ☐ Triceps Pad	
Additional Instructions:	

PATIENT MEASUREMENTS:



CABLE:

Standard Heavy Duty



TRICEPS PAD MEASUREMENT: