		jo	Vi		Cu	sto	m Jo	o V i E	Bust	i (	Orde	er Fo	rn	n		
PAK®					Patient Name:					Date:						
<u>Step 1:</u>					Female Male						Primary Secondary					
Please fill in the patient information.				ıπon.	Oth			Mastectomy			Lumpectomy			Right		Left
Patien	t D.O.B.	Mo	Day	YR	Height	ft	in	Weight		lb:	s Bra S	ize		Blouse	Size	
Step	2:							P-PI	Pad							
Choose option(s) from the Additional Charge									Color Options							
Options Chart below.								Polartec®								
						- 1						Black*			Leaf	f Green*
Additional Charge Options										Buff			Purple Heart			
P-PI Padded Insert - Equalizes pressure over chest wall.										French I	Blue		Royal Blue*			
	Choose I	Pad Size:	☐ A	/B		: [	☐ D		DD/E			Glacier	Blue		Stai	nless Steel
	JoViJacke	et - White	e or Bla	ck.								Pink*			] Whi	ite
Step 3:										*Polartec® Polygiene® odor resistant fabric.						
Choose a Busti color. &a JoViJacket color from the Color Options Chart to the right.								ht.	JoViJackets							

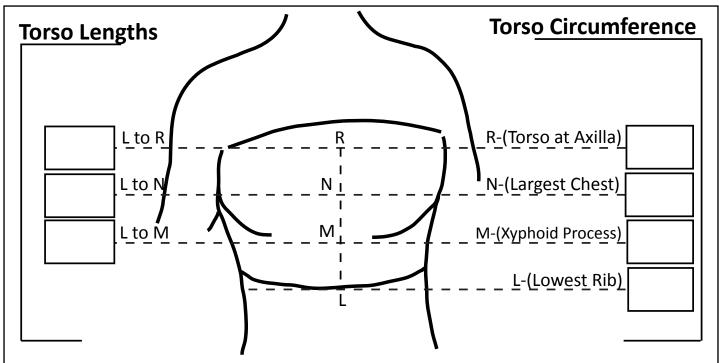
Black

White

## **Step 4:**

Record patient's measurements on chart below. (Optional for size verification.)

The JoViJacket is an Additional Charge Option which must be checked in step 2.



## Step 5:

Fax completed form to 202-895-6948.

Your order must include information from Step 1, additional charge options, Length, Busti color and JoViJacket color, completed measuring form and the billing and shipping form.



Date		PATIENT INFORMATION:								
Customer ID #	#:			Patient Name:						
PO #:				Previous Patient: Yes No						
Fax Confirmation #	#:		Measuring Therapist:							
Confirmation Email:				Therapist Phone:						
BILLING ADDRI		SHIPPING ADDRESS: Same as Billing.								
Business Name:		Business Name:								
Attention:				Attention:						
Email:				Address:						
Address:				City:				State:		
City: State:				Phone:			Zip:	Zip:		
Phone:		Zip:								
SPECIFY SHIPPING:										
PAYMENT INFO	Business Address Residential Address*									
Check (Payable to	JoViPak Corporation)	*Residential addresses are an additional \$10 and this includes home businesses.								
U VISA	D:									
Exp. Date:	Ground 2nd Day				Air					
Card #:		3-Day Select Next Da				y Air				
Printed Cardholder Name:										
		QUANTITY								
	_									
		<u> </u>								
ORDER SPECIFICATIONS:										
	5% Up-Charge (Cus	uote & Proceed	ceed If neither Quote box is checked the order will be processed immediately.							
48 Hour Rush - 25% Up-Charge				uote Only	Prepaid Reduction Option					