

Patient Name: \_\_\_\_\_

## PAYMENT INFORMATION

|   |  |      |
|---|--|------|
| Account #<br>(Required)                     | <input type="checkbox"/> Bill to Account                 | Date |
| <input type="checkbox"/> Charge Credit Card | <input type="text"/> <input type="text"/> 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



Vest with optional Full Padding  
(shown with vertical & horizontal  
padding options for illustration)



Vest with JoViJacket

### Organic Cotton & Spandex Colors

|                                | QTY |                                | QTY |
|--------------------------------|-----|--------------------------------|-----|
| <input type="checkbox"/> Black |     | <input type="checkbox"/> Ivory |     |

### JoViJacket - Nylon & Spandex Powernet

|                                | QTY |                                | QTY |
|--------------------------------|-----|--------------------------------|-----|
| <input type="checkbox"/> Black |     | <input type="checkbox"/> 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

# Vests 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

## Circumference

Please record all measurements in centimeters  
All measurements are required.

## Lengths

Lengths should be taken along the side of the torso, starting at the waist (with a beginning number of O), measuring up to the axilla (R).

The lower section beginning at K (Natural Waist), is a 20cm long unpadded/unchanneled peplum.

K (front) through the Groin and to K (back)  
(for Crotch Straps only - measure from center front waist, through the crotch, and up to the center back waist)

### Additional Charge Options

**Padded Insert**  
(equalizes pressure over mastectomy site)

Color: ☐ Black ☐ Buff

Size: ☐ Small (A/B)

☐ Medium (C)

☐ Large (D)

☐ XLarge (DD/E)

☐ Crotch Strap

(helps to keep garment in place for patients with larger abdomens (additional measurements required))

☐ Prepaid Reduction

☐ Full Vertical Padding to natural waist - peplum included

### No Charge Options

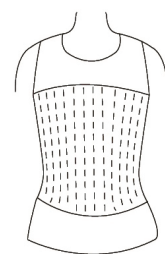
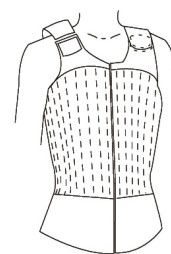
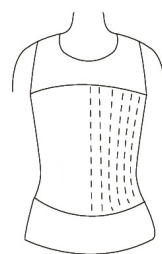
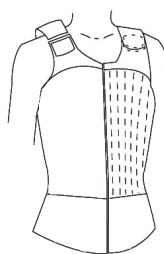
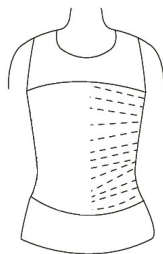
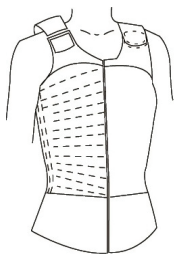
☐ Slimline (more channels and less foam)

☐ Two Blend Foam (Low ILD)

☐ End garment at waist (no peplum)

• Pictures are needed if the patient has lobules, is over-sized or has some other issue. Please send pictures (no patient faces) to info.jovipak@essity.com.

## Channeling Options



☐ Half Padding Horizontal

☐ Left ☐ Right

☐ Half Padding Vertical

☐ Left ☐ Right

☐ Bilateral Vertical

(additional charge)

Fitter/Therapist Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

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