

Name des Patienten		Geburtsdatum	Geschlecht	Datum der Vermessung
		... / ... / ...	<input type="checkbox"/> m <input type="checkbox"/> w	... / ... / 201 ..
Gemessen von	Unterschrift	Kontaktperson		Abteilung

Umfang

Länge

AB

AC

CD

CE

ED

EF

FD

BD

KCK

GH

H*

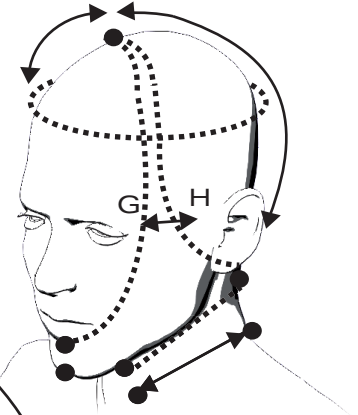
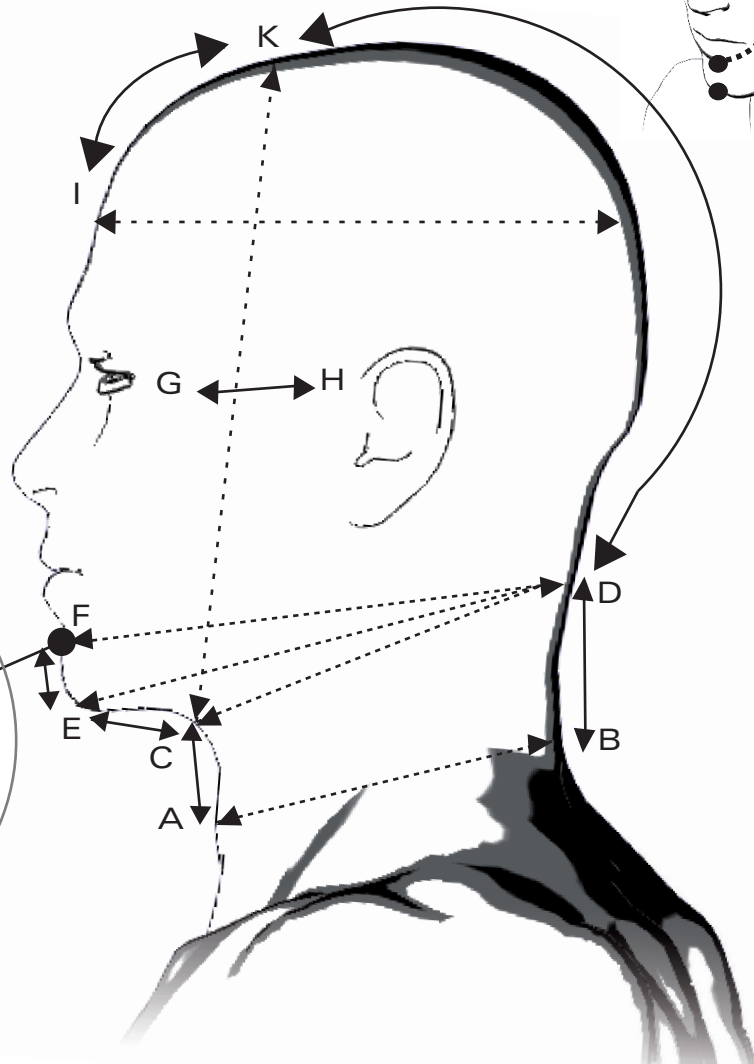
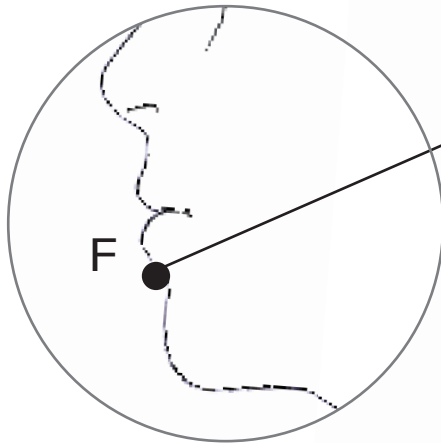
KD

I

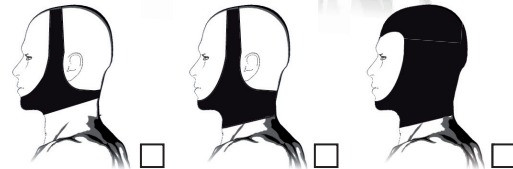
IK

! Maßangabe in cm

* H links über Augenpartie/Gesicht bis H rechts



<input type="checkbox"/>	POLYAMIDE	<input type="checkbox"/>	SILIKON



Bemerkungen:

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