

Name patient		Date of Birth	Gender	Date of Measuring
		... / ... / ...	<input type="checkbox"/> m <input type="checkbox"/> f	... / ... / 201 ..
Measured by	Signature	Contact Person	Department	

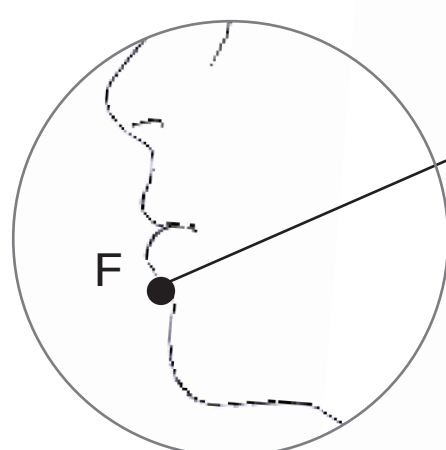
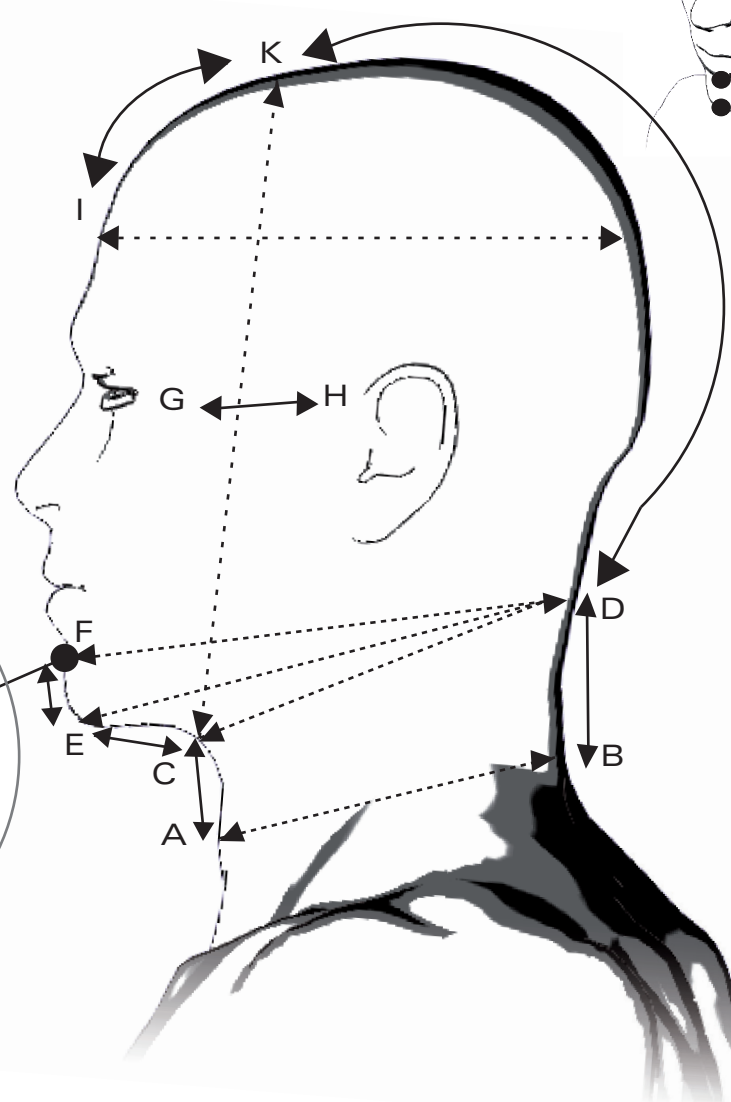
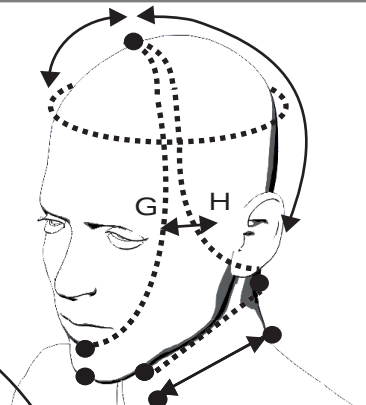
Circumference

Length

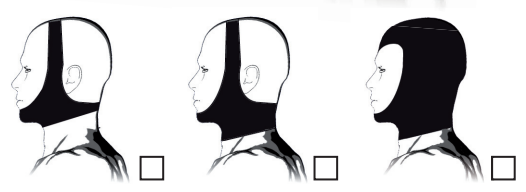
AB	AC
CD	CE
ED	EF
FD	BD
KCK	GH
H*	KD
I	IK

! measures in cm

* H left over head to H right



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



Remarks:

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