L&R INTERNAL USE ONLY

TributeNight™ Facial Order Form

1 Patient Information

Name: _____ Phone Number: _____ Age: _____ Height: _____ Weight: _____

Therapist/Fitter: Name: _____ Phone Number: _____ Email: _____

2 Garment Design

Style FN - _____

Channeling (Default channeling varies based on garment style.)

Profile ☐Original ☐Low

Color ☐Black (Only available in black.)

Modifications

QTY.	Notes/Placement Instruction
___ Lip bridge	
___ Tracheotomy accommodation	

Special Instructions:

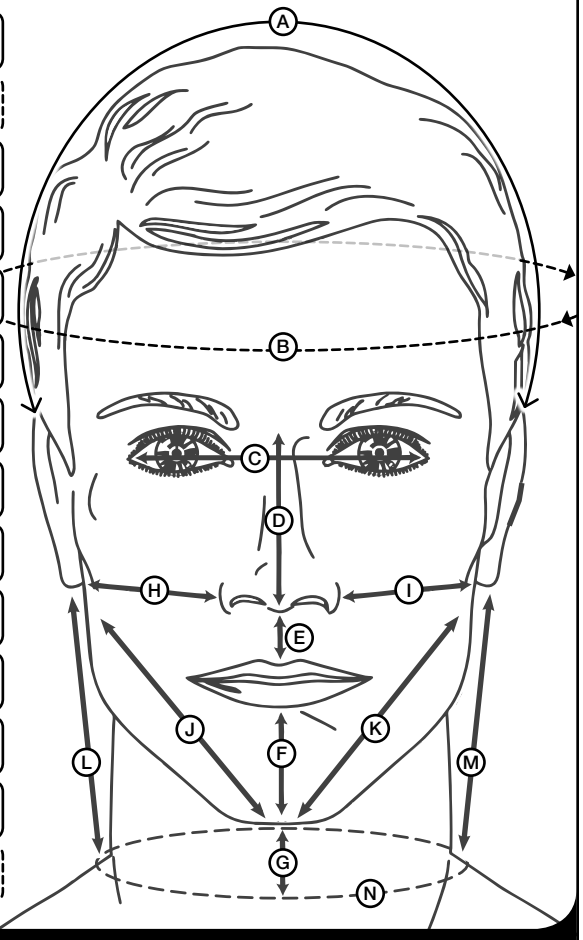
☐Exact Reorder of Order #: _____

3 Measurements

(All measurements in centimeters)

Date taken: ___ / ___ / ___

A= B= C= D= E= F= G= H= I= J= K= L= M= N=



Denote areas of scarring or fibrosis with hash marks (////).

4 Billing Information

☐Quote Only

Business Name: _____

Phone: _____ Fax: _____

Contact Name & Phone: _____

Account #: _____ P.O. #: _____

Payment: ☐Credit card (provide number below) ☐Net 30

Card #: _____ Exp: ___ /___ SID: ____

5 Shipping Information

Shipping: ☐Standard 4-Day Guarantee*
☐Priority Requested Delivery Date: _____

Ship to: _____

Attn: _____

Street: _____

City: _____ State: _____

Zip: _____

Phone: _____

Email (for shipping notification): _____

Fax completed order to 772-589-0306 or **email** to sales@acols.com
We will reply with an order confirmation and cost.
Questions? Call us at 800-863-5935.

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