

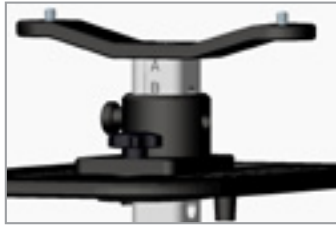
Patient Name _____

Date _____

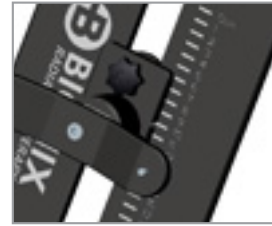
Area of RX- orientation _____

Patient I.D. _____

Adjustable Face Cushion



A B C D E F



Superior / Inferior (1-20) _____

Treatment Base

Indexed to Couch @ _____ + _____

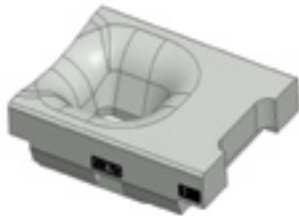
Securefit Bar Top

A1 B1 C1 D1 E1 F1

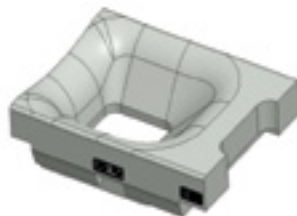
Securefit Bar Bottom

A2 B2 C2 D2 E2 F2

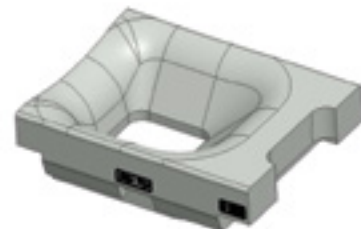
Treatment Area



Small



Medium



Large

Ankle Cushion Used? **Yes** **No**

(*Ankle Cushion Purchased Separately)

Notes