

Patient Name _____

Date _____

Area of RX- orientation _____

Patient I.D. _____

Shoulder Suppression

- None
- HNRT-6042 Carbon Fiber Shoulder

Suppression

LEFT:

Height: 1 2 3 4 5 6 7

Position: Inner Outer Center

Orientation: A B C D E F G H

RIGHT:

Height: 1 2 3 4 5 6 7

Position: Inner Outer Center

Orientation: A B C D E F G H

Ruler

