



Patient ID: _____

Date: _____

| | |
|---|-----------------------------|
|  | <input type="checkbox"/> B1 |
| | <input type="checkbox"/> B2 |
| | <input type="checkbox"/> B3 |
| | <input type="checkbox"/> B4 |
| | <input type="checkbox"/> B5 |
| | |
| T-shaped hand grip | |

| | |
|--|-----------------------------|
|  | <input type="checkbox"/> A1 |
| | <input type="checkbox"/> A2 |
| | <input type="checkbox"/> A3 |
| | <input type="checkbox"/> A4 |
| | <input type="checkbox"/> A5 |
| | <input type="checkbox"/> A6 |
| | <input type="checkbox"/> A7 |
| | <input type="checkbox"/> A8 |
| T-shaped hand grip | |

| | |
|---|---|
|  |  |
| Orfit | Silverman |
| Head support | |

| | |
|--|--|
| Additional Positioning Elements | |
| Position of 2-pin indexing bar on the couch: | |
| Others/remarks | |
| | |

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