Patient-Specific Implant Order Form

What We Need:
1. CT scan with raw DICOM data on disc
2. Completed order form

Send It To:
1768 East 25th Street, Cleveland, Ohio 44114
For electronic ordering options, please call 216-881-8500

Surgeon Information

Surgeon Name: ______________________________ Phone: ______________________

Address: ____

Fax: __________________ Email: ______________________________

Nurse Manager/Other Contact Person: ______________________________

Phone: __________________ Email: ______________________________

Hospital Information

Hospital Name: ______________________ Purchasing Contact: ______________________

Phone: __________________ Email: ______________________________

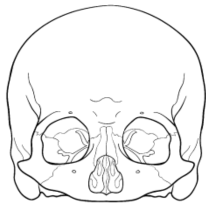
Patient Information

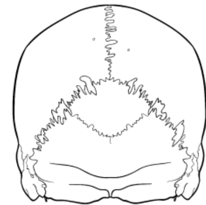
Patient Name: ______________________________ Patient ID: ______________________

Age: ________ Sex: ________ Desired date of implant surgery: ______________________

Implant Specifications

Please mark the location of the defect: Approx. date defect acquired: ______________________





Please specify implant design instructions:

Finish (check one): ❑ Clear ❑ Opaque ❑ Textured

Implant profile (check one): ❑ Match contralateral anatomy for cosmesis ❑ Lowered for soft tissue closure

Price and lead time will be quoted after receipt of CT scan and order form.

Surgeon Signature: ______________________________ Date: ______________________

Sales Rep Information

Name: ______________________________ Phone: ______________________