# PRODUCT REQUEST FORM

## 1. SURGEON DETAILS

<table>
<thead>
<tr>
<th>Surgeon Name</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Surgeon Address</th>
<th></th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Phone No.</th>
<th>Fax No.</th>
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</table>

## 2. PRODUCT DETAILS

**Product Type**
- [ ] Implant
- [ ] Surgical BioModel
- [ ] Other

**Material Type:** (Implants only)
- [ ] Acrylic
- [ ] Titanium
- [ ] Silicone
- [ ] StarPore
- [ ] TBC

**Fixation Type:** (Implants only)
- [ ] Straight plates
- [ ] Double-Y plates
- [ ] Clamp
- [ ] TBC

**Additional Options:** (Implants only)
- [ ] Pre-drill 3mm dura/drainage holes (standard)
- [ ] Pre-drill temporalis muscle suture holes
- [ ] Include a resection template (for bony tumour cases)
- [ ] Provide Implant sterile (adds 1 week to delivery)

**BioModel requirements or clinical details**

## 3. SURGERY DETAILS

<table>
<thead>
<tr>
<th>Surgery Date</th>
<th>Required Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</table>

**Delivery Address**
<table>
<thead>
<tr>
<th>Receiver’s Name</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

## 4. PATIENT DETAILS

**Patient Name**

**Date of Birth**

**Sex**
- [ ] Male
- [ ] Female

## 5. BILLING DETAILS

**Invoice who?**
- [ ] Hospital
- [ ] Patient
- [ ] Insurance Co.
- [ ] Other (Please specify)

**Details**

## 6. RADIOLOGY

**CT scan done?**
- [ ] Yes
- [ ] No
- [ ] If No, when & where?

## 7. CONTACT DETAILS

<table>
<thead>
<tr>
<th>Ordered by (Print)</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Mail with CT scan on disc to the address below or fax this form to: **+613 9529 8099**