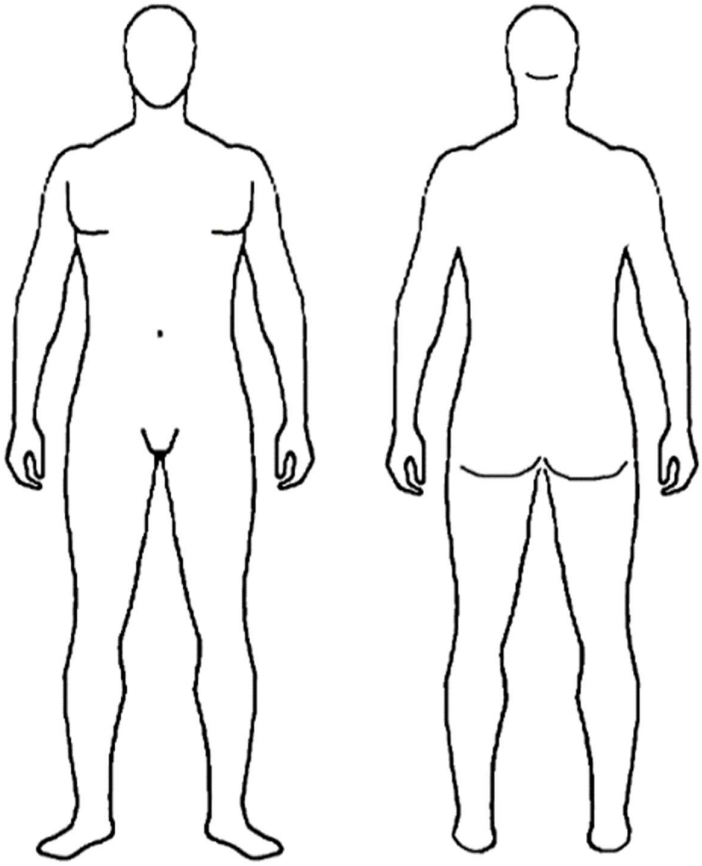
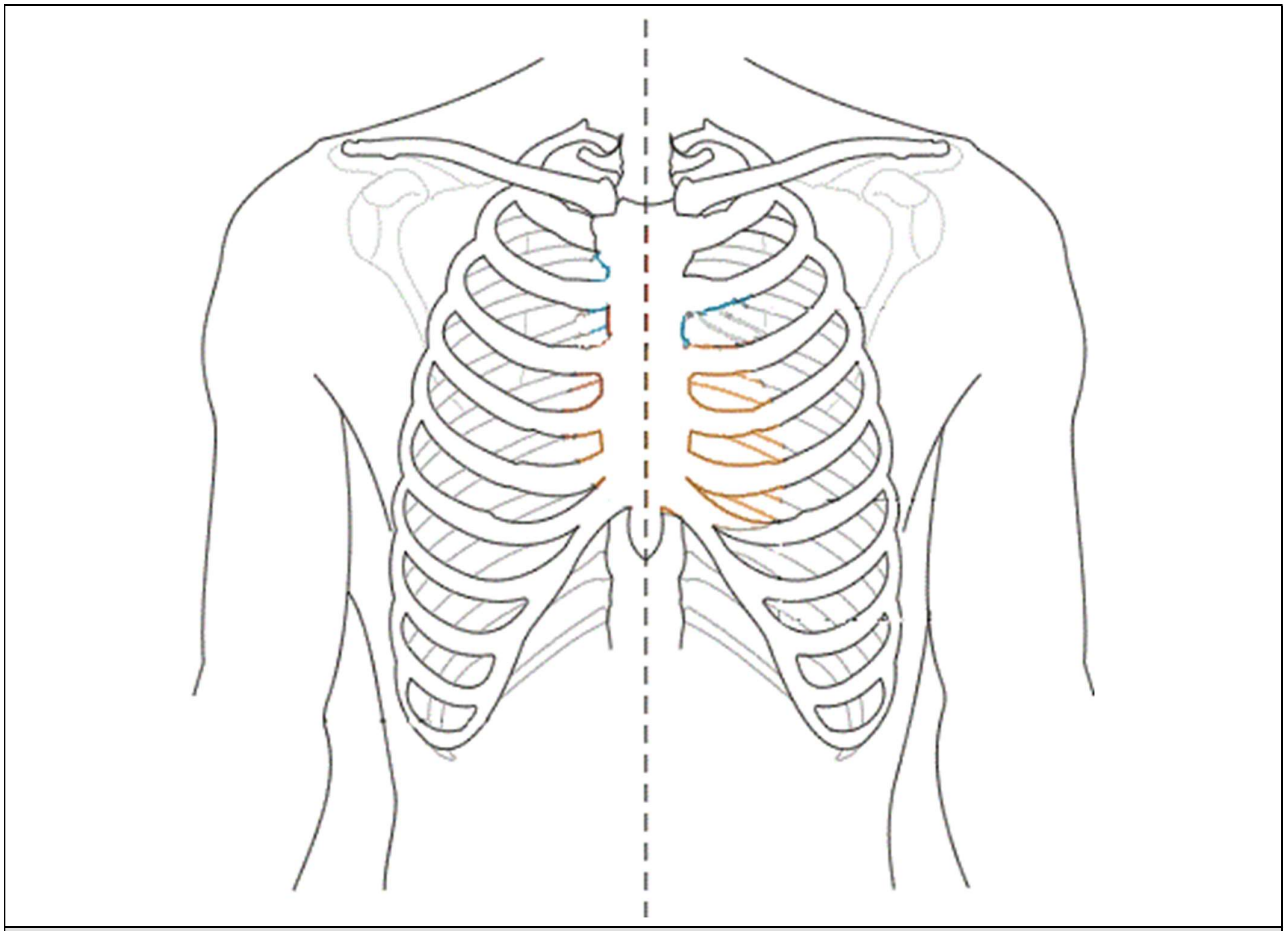
**SILICONE PATIENT SPECIFIC IMPLANT DESIGN FORM**

| **1. SURGEON DETAILS** | | | |
|---|---|---|---|
| Surgeon Name: | | Specialty: | |
| Email: | | Phone: | |
| **2. PRODUCT DETAILS** | | | |
| Region: | ☐ Chest ☐ Face ☐ Arm ☐ Leg ☐ Other | | |
| Options: | ☐ Suture tabs ☐ Textured ☐ Not sure – contact me to discuss | | |
| Durometry: | ☐ Firm ☐ Medium ☐ Soft ☐ Very Soft ☐ Extra Soft | | |

Where will the implant be located? Please indicate the location (front, back, left, right)





| **3. SURGERY DETAILS** | | | |
|---|---|---|---|
| Surgery Date: | | Required Date: | |
| Delivery Address: | | | |
| Receiver's Name: | | | |

| **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. CONTACT DETAILS** | | | |
|---|---|---|---|
| Ordered by: (Print) | | Email: | |

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