Ossis™ Custom Oncology Implant Prescription

OSSIS

Please complete all sections and send this form to Ossis™.
Ossis™ will send you a quote for a custom implant based on the requirements identified on this form.

Patient Name: ____________________ DOB: ____________ NHI/REF: ________

Indicative Surgery Date: ____________________ Hospital: ____________________

Surgical approach: ☐ Posterior ☐ Direct Lateral ☐ Anterior Lateral ☐ Other: __________

Implant for: ☐ Left side ☐ Right side

Tumour Margin: ______ cm

Additional Requirements: ______________________________

	Pathology	Type/Details	Area/Location
☐	Tumour		
☐	Post Radiation		
☐	Infection		
☐	Arthritis		
☐	Fracture		
☐	Avascular Necrosis		
☐	Osteolysis		
☐	*Other*		

Acetabular Articulation Preference:

☐ Neutral-face Poly ☐ Hooded Poly ☐ Constrained ☐ Dual Mobility ☐ Ceramic

Preferred Head Size: ______ mm **Preferred Stem:** ____________ **Company:** ________

CT Scans	XRAYS	MRI	*(Ossis™ protocol and uploading instructions on website – www.Ossis™.com)*
☐	☐	☐	*Available on CDHB PACS (Any NZ DHB PACS can request data transfer)*
☐	☐	☐	*Available on Ossis™ Image Share (Share link: http://Ossis™.dicomgrid.com/share/Ossis™)*
☐	☐	☐	*Other (e.g. CD or USB):* ______________________

Imaging Centre details: ______________________________

Prescriber's Name: ____________________ Email: ____________________

Office phone number: ____________________ Mobile phone number: ____________________

Prescriber's Signature: ______________________________ **Date:** ________