Craniomaxillofacial Model Prescription Form

Please complete all sections below and send the form back to OSSIS, via one of the options below:
Email: info@ossis.com, Fax: +64 3 365 9486, Post: PO Box 42129, Tower Junction, 8149, New Zealand.

PRESCRIBER DETAILS

1. Surgeon full name:
2. Email:
3. Contact number:
4. Office contact details:

PATIENT DETAILS

5. Patient full name:
6. Date of birth (dd-mmm-yyyy):
7. NHI (NZ only): ☐ N/A
8. Surgery date (dd-mmm-yyyy): ☐ Confirmed
9. Hospital: ☐ Public ☐ Private
10. Affected side: ☐ Left ☐ Right ☐ Other:

MODEL REQUIREMENTS

11. Anatomy:	☐ Full Skull	☐ Mandible	☐ Maxilla	☐ Orbits
12. Mirror selection: (Mirrored model of anatomy)	☐ Yes	☐ No		
13. Digital reconstruction: (Model of desired patient outcome)	☐ Yes	☐ No		

14. Additional information:

SHIPPING DETAILS

15. Model shipping address:

OSSIS also requires a CT scan[1] of the patient.
Please contact OSSIS to communicate how imaging will be shared.

Prescriber Signature: _____ **Date:** _____

[1] OSSIS Custom Implant Scan Protocol can be found on the OSSIS website: www.ossis.com/resources
OSSIS Patient Health Information Privacy Policy can be found on the OSSIS website: www.ossis.com/resources