



MEDICAL MODEL REQUISITION

clinical external form

Fax or email this form to:
Sandie Pouliot, iRSM Patient Scheduling

- 780-735-2658
- Sandie.Pouliot@albertahealthservices.ca
- 780-735-2660

ALL SECTIONS MUST BE COMPLETED

1 REFERRING CLINICIAN INFORMATION

Clinician _____ Contact Name _____ Date: MM/DD/YYYY

Address _____ City _____

Province/State _____ Country _____ Postal Code/ZIP code _____

Phone # _____ Fax # _____ Email _____

MODEL REQUIRED BY DATE
(MINIMUM 3 WEEKS from date of scan)
MM/DD/YYYY

! Please ensure that iRSM is advised of the date the model is required by. Without the date, delivery of the model cannot be guaranteed. **If you change your scheduled surgery date, please remember to inform iRSM.**

Is the requested model to be used for a procedure covered by Alberta Health Services? Yes No

2 PATIENT INFORMATION

Personal Health #

Last Name _____ First Name _____ Middle _____ DOB: MM/DD/YYYY

Address _____ City _____

Province/State _____ Country _____ Postal Code/ZIP code _____

Home Phone # _____ Work Phone # _____ Other _____

3 SCAN DATA

Where possible, to ensure that scanning is performed to the required protocol, we prefer scans are arranged through our office. Please indicate if you would like the scan to be arranged through iRSM.

YES, please arrange to have this patient scanned through iRSM and the MCH

! Please ensure that Scans are performed according to the required protocol: **helical axial scan | 1 x 1 mm slices | 0° gantry | standard algorithm**
Scans that are performed at slice distances >1mm compromise the detail and accuracy of models
Scans that are performed at facilities without PACS must have dicom image data written to CD

Where was the scan performed? _____ Contact Name/Phone # _____ Date of scan: MM/DD/YYYY

Type of scan performed: CT MRI Laser Scan Cone Beam



For Office Use Only

Ref#

Start Date

End Date



4 MEDICAL MODEL STUDY INFORMATION

Planned Surgical Procedure: _____

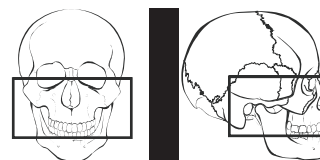
Diagnosis/Relevant history: _____

Please indicate the area of interest:

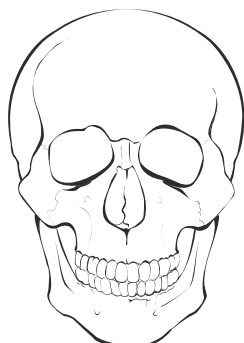
- | | | | | |
|---|--|---|---|---------------------------------------|
| <input type="checkbox"/> Surface Features | <input type="checkbox"/> Bony Skeleton | <input type="checkbox"/> Maxilla | <input type="checkbox"/> Midface (orbits to occlusal plane) | <input type="checkbox"/> Full Cranium |
| | <input type="checkbox"/> Mandible | <input type="checkbox"/> Cranial Skull Base | <input type="checkbox"/> Full Skull | <input type="checkbox"/> Other _____ |

Please indicate with a box or shading, the extent of the anatomical model required in the illustrations below.

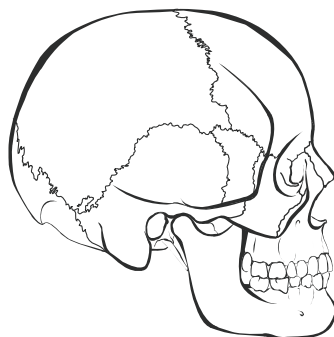
Example: Anterior Maxilla



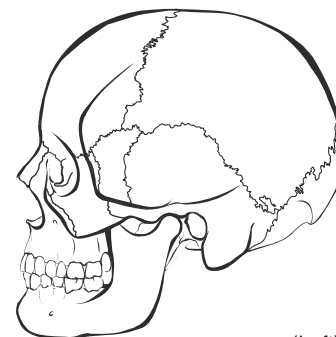
This section must be completed.



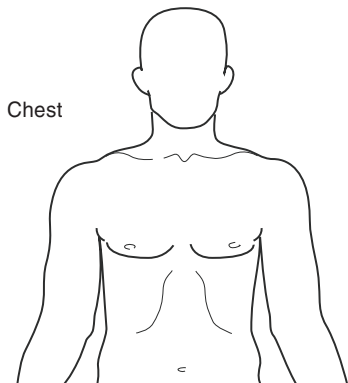
Frontal Skull



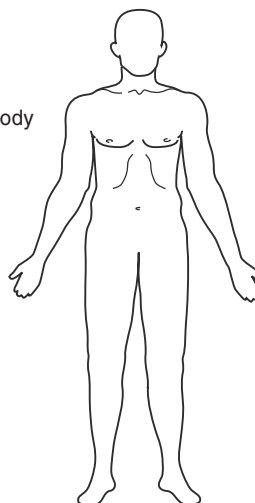
Lateral Skull (Right)



(Left)



Chest



Full Body

If a model is too large for the printing device, it may need to be split into sections (i.e. models of the full skull). Please indicate with a dotted line where the model can be split. Thank you for completing this form. We appreciate the opportunity to work with you.
Please do not return medical models unless they are iRSM patients.

Please contact the MMRL (Medical Modeling Research Laboratory) with any technical questions. Phone: 780-735-2815.



5 SURGERY PLANNING AT iRSM

1) Type of Surgery to be performed

Maxillectomy

Mandibular

Reconstruction

Marginal

1°

Segmental

2°

Orbit

Skull Base

Other: _____

Information on planned procedure: _____

2) 1° Resection Surgeon _____

1° Reconstruction Surgeon _____

3) Treatment Planning Required at iRSM

Functional Assessment

Maxillofacial Prosthodontic Treatment Planning

Laser Scan of the Head and Neck

Facial Prosthetic Consult

SIM/Plant Study

Digital Images

Please specify: _____

Please show lines of resection:

Maxilla

Mandible

Skull

