



# MEDICAL MODEL REQUISITION

clinical external form

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

- 780-735-2658
- Sandie.Pouliot@capitalhealth.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.**

### 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: \_\_\_\_\_  
\_\_\_\_\_

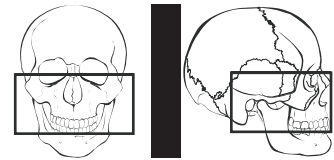
Diagnosis/Relevant history: \_\_\_\_\_  
\_\_\_\_\_

Please indicate the area of interest:

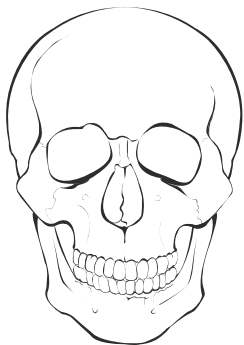
- Surface Features
- Bony Skeleton
- Maxilla
- Midface (orbits to occlusal plane)
- Full Cranium
- Mandible
- Cranial Skull Base
- Full Skull
- Other \_\_\_\_\_

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

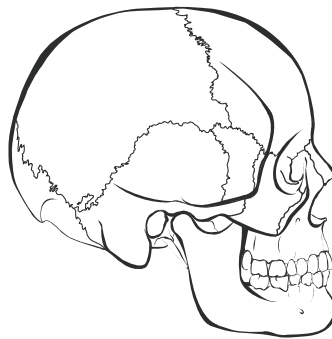
Example: Anterior Maxilla



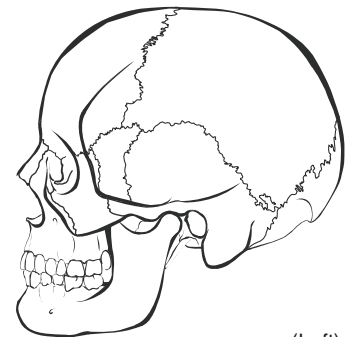
This section must be completed.



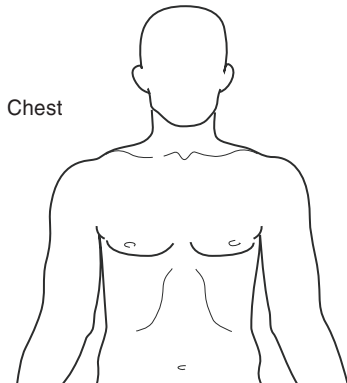
Frontal Skull



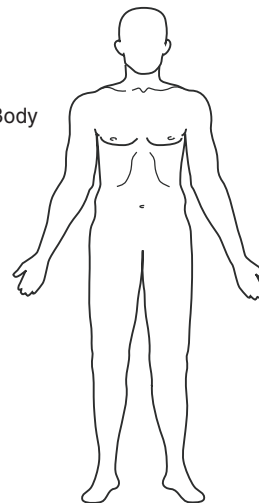
Lateral Skull (Right)



(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

- |                                       |   |   |
|---------------------------------------|---|---|
| <input type="checkbox"/> Maxillectomy | <input type="checkbox"/> Mandibular       | <input type="checkbox"/> Reconstruction |
|                                       | <input type="checkbox"/> <i>Marginal</i>  | <input type="checkbox"/> 1°             |
|                                       | <input type="checkbox"/> <i>Segmental</i> | <input type="checkbox"/> 2°             |
| <input type="checkbox"/> Orbit        | <input type="checkbox"/> Skull Base       | <input type="checkbox"/> Other: _____   |

Information on planned procedure: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2) 1° Resection Surgeon \_\_\_\_\_

1° Reconstruction Surgeon \_\_\_\_\_

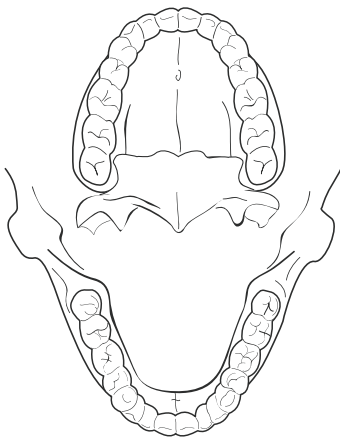
3) Treatment Planning Required at iRSM

- |  |   |
|--|---|
| <input type="checkbox"/> Functional Assessment           | <input type="checkbox"/> Maxillofacial Prosthodontic Treatment Planning |
| <input type="checkbox"/> Laser Scan of the Head and Neck | <input type="checkbox"/> Facial Prosthetic Consult                      |
| <input type="checkbox"/> SIM/Plant Study                 | <input type="checkbox"/> Digital Images                                 |

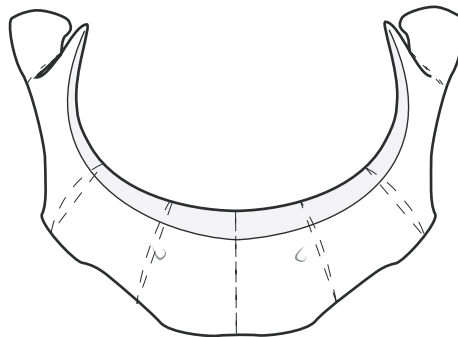
Please specify: \_\_\_\_\_

Please show lines of resection:

Maxilla



Mandible



Skull

