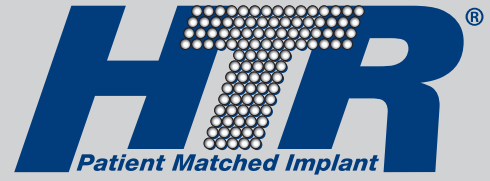


Surgeon Order Request Form



PATIENT INFORMATION

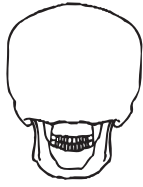
Name: _____ Diagnosis: _____

Age: _____ Location of Defect: _____ Approximate Size of Defect: _____

IMPLANT INFORMATION [Circle area(s) to be reconstructed]



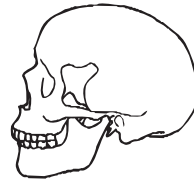
A/P View of Skull



P/A View of Skull



Right Lateral



Left Lateral



Top View



Mandible

Specify Implant Design Instructions (if any): _____

SURGEON INFORMATION

Type of Surgeon: [Circle one] Neurosurgeon, Plastic and Reconstructive, Oral, Otolaryngology, Other (Specify): _____

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____ Contact Person: _____

Email Address: _____

HOSPITAL INFORMATION

Hospital Name: _____

Address: _____

Phone Number: _____

SCANNING FACILITY INFORMATION

Name of Scanning Facility: _____

Address: _____

Phone Number: _____ Contact Person: _____

W. Lorenz Surgical's privacy statement is available at www.lorenzsurgical.com or please contact us at 800-874-7711 for more information.

Please send this Order Request Form with the Patient's CT Data to Medical Modeling, Inc. at
HTR-PMI Dept., 17301 West Colfax Ave., Suite 301, Golden, CO 80401