# **Request for Quote**

 Patient Specific Implants

**Please send:**

1. Completed “Request for Quote” form
2. CT Scan/Optical Disc from radiology (with scanner type, date of scan, patient name/number on disc)

**Mail to:**

Attn:2F, Unit 01, Building A, Haikexing Industrial Zone, Jinlong Avenue, Pingshan New District, Shenzhen City, Guangdong Province, China

**Surgeon and Shipping Information:** Patient Specific Implants and skull models must be shipped directly to surgeon; Please indicate exact name and location for model and implant to be shipped.

Surgeon name Hospital name /Account number

Phone number E-mail address

Secondary contact information (name, e-mail address, phone number)

# Ship to Account, attn:

# Other: (address, city, state, zip)

Patient number / name Date of planned surgery

**Implant Information**

*suggests that surgery not be scheduled until Double Medical receives the product and the surgeon completes design validation.*

|  |  |  |
| --- | --- | --- |
| Patient name\* |  | Planned surgery date |
| Patient ID number\* |  Scan date\* |  |
| Implant material:\* | ❏ Titanium |  |
| Design validation method (choose one):\* | ❏ Skull model | ❏ CAD images via e-mail |

Description of defect(location, size, quantity)\*

Approximate defect location and shape (please draw/annotate defect)



\*Denotes required fields