

unique

ORDER FORM

PURCHASE OF *unique* CUSTOM FEMORAL PROSTHESIS:

- 1 - Fill out all fields in this "order form" and ship form to SCP.
- 2 - Purchase for CT-scanning at your radiological department.
- 3 - If it is a special case or a bilateral purchase order, ship a copy of the pelvic x-ray of the patient.

Scandinavian Customized Prosthesis as
Hornebergv. 7A
N - 7038 Trondheim
Norway
Telephone: +47 73 40 17 70
Telefax: +47 73 96 31 90
Web: <http://www.scp.no>
e-mail: support@scp.no

ORDER FORM

PATIENT DATA

Name: _____

Sex: male female

Personal id no: _____

Body weight: _____ (kg- appr)

DESIGN DATA

Hip side: right left

Clinical leg length difference: _____ mm to short to long

Planned correction
of leg length:

X-ray leg length difference: _____ mm to short to long

_____ mm shorter

longer

DIAGNOSIS

ACTUAL HIP CONTRALATERALHIP

- | | | |
|--------------------------|----------------------------|--------------------------|
| <input type="checkbox"/> | Primary osteoarthritis | <input type="checkbox"/> |
| <input type="checkbox"/> | RA | <input type="checkbox"/> |
| <input type="checkbox"/> | CDH | <input type="checkbox"/> |
| <input type="checkbox"/> | Sequele after hip fracture | <input type="checkbox"/> |
| <input type="checkbox"/> | Perthes disease | <input type="checkbox"/> |
| <input type="checkbox"/> | Avascular necrosis | <input type="checkbox"/> |
| <input type="checkbox"/> | Posttraumatic | <input type="checkbox"/> |
| <input type="checkbox"/> | Other | <input type="checkbox"/> |
| <input type="checkbox"/> | Normal | <input type="checkbox"/> |

Bilateral prosthesis planned: yes no

If "yes" order for bilateral CT-scanning

PREVIOUS PROCEDURES

ACTUAL HIP CONTRALATERALHIP

- | | | |
|--------------------------|-----------------------|--------------------------|
| <input type="checkbox"/> | None | <input type="checkbox"/> |
| <input type="checkbox"/> | THR | <input type="checkbox"/> |
| <input type="checkbox"/> | Osteosynthesis | <input type="checkbox"/> |
| <input type="checkbox"/> | Arthrodesis | <input type="checkbox"/> |
| <input type="checkbox"/> | Osteotomy, femoral | <input type="checkbox"/> |
| <input type="checkbox"/> | Osteotomy, acetabulum | <input type="checkbox"/> |
| <input type="checkbox"/> | Other | <input type="checkbox"/> |

COMMENTS

CT scanning purchased ok

X-rays shipped to SCP ok

Date: _____

Signature: _____