

CASE INFORMATION			
Patient Name		Surgery Date	___ / ___ / ___ <input type="checkbox"/> Not Scheduled
Hospital		Requested Meeting	___ / ___ / ___ at ___ : ___ AM PM Will be confirmed after ALL data submitted.
Surgeon		Surgeon Time Zone	
Distributor		Rep Phone	
Representative		Rep Email	
HEAD & NECK PLAN			
Surgical Access	<input type="checkbox"/> Intraoral <input type="checkbox"/> Extraoral	Diagnosis	<input type="checkbox"/> Malignant <input type="checkbox"/> Benign <input type="checkbox"/> N/A
<b>Resection Plan</b> Use the area to the right to draw the following details.  Draw   for resection lines  Additional Notes:			
GRAFT SITE PLAN <input type="checkbox"/> N/A, Graft Site Not Required			
Graft Data	<input type="checkbox"/> Patient Specific <small>Requires CT of Graft Site.</small> <input type="checkbox"/> Generic	Predicted # of Segments	___ segment(s)
Graft Region	<input type="checkbox"/> Fibula <input type="checkbox"/> Scapula <input type="checkbox"/> Iliac Crest <input type="checkbox"/> Other:	Relative Graft Position	<input type="checkbox"/> Flush with Inferior Border <input type="checkbox"/> ___ mm above inferior border
Graft From	<input type="checkbox"/> Left <input type="checkbox"/> Right	Pedicle Emerges	<input type="checkbox"/> Ant. <input type="checkbox"/> Post. <input type="checkbox"/> Left <input type="checkbox"/> Right
ACCUPLATE <input type="checkbox"/> N/A, Patient-Specific Mandible Plate Not Required			
Screw Manufacturer		Plate Thickness	___ mm
Plate Instructions			