ACCUSTRIDE® | SERVICE REQUEST

We ***cannot*** start your case without the following information:

CASE INFORMATION

Patient Name		Surgery Date	___ / ___ / ___ ☐ 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	

PATHOLOGY AND BACKGROUND

What is patient diagnosis? *Please provide relevant details below:*

Does the patient have any medical conditions that may affect bone quality? ◯ No ◯ Yes, Please Specify

SURGICAL PLAN

Affected Foot	☐ Left ☐ Right	Weight Bearing CT	◯ Yes ◯ No
Surgical Access	☐ Medial ☐ Lateral ☐ Dorsal	Existing Hardware?	◯ Yes, Keep ◯ Yes, Remove ◯ No

Surgical Summary *Please provide relevant details below*

Custom Plates ◯ Yes ◯ No

Will you be using any additional implants, guides, or surgical planning services from another company for this case?
◯ No ◯ Yes, Please Specify:

INSTRUMENTATION

Screw Manufacturer	
Screw Size:	

NOTES

Additional Instructions:

Printed in USA | STR-FPS-012 (B)

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