

Craniomaxillofacial evaluation questionnaire

Renishaw case number (for internal use only)			
Hospital name		Hospital address	
Surgeon name			
Prosthetist name			
Patient age			
Procedure date		Procedure type	

Reason for procedure	Cancer treatment <input type="checkbox"/>	Trauma reconstruction <input type="checkbox"/>	Congenital defect correction <input type="checkbox"/>
	Other <input type="checkbox"/> Please specify: _____		
Was this a revision of a previous procedure?	No <input type="checkbox"/>	Yes (LaserImplant™) <input type="checkbox"/>	Was it necessary to explain the original LaserImplant? Please give details below.
	Yes (alternative brand) <input type="checkbox"/> _____		

Which autologous flap was used?	None <input type="checkbox"/>	Fibula <input type="checkbox"/>	DCIA <input type="checkbox"/>	Scapula <input type="checkbox"/>
	Other <input type="checkbox"/> Please specify: _____			
Were any non custom plates/implants used in surgery?	No <input type="checkbox"/>			
	Yes <input type="checkbox"/> Size: _____ Manufacturer: _____			
Were any retaining screws used?	No <input type="checkbox"/>			
	Yes <input type="checkbox"/> Brand: _____ Diameter: _____ Length: _____			
Was surgery navigation used? (example: Brainlab)	No <input type="checkbox"/>			
	Yes <input type="checkbox"/> Name of surgery navigation: _____			
Was a post-operative CT taken?	No <input type="checkbox"/>			
	Yes <input type="checkbox"/>			

Design of your LaserImplant

Where was the LaserImplant design carried out and by whom?	_____		
What software was used for implant design and/or planning surgery? (Please select all that apply)	Materialise Mimics® <input type="checkbox"/>	Materialise 3-matic <input type="checkbox"/>	
	PROPLAN <input type="checkbox"/>	Geomagics® Freeform® <input type="checkbox"/>	
	Other <input type="checkbox"/> Please specify: _____		

Usability of your LaserImplant

Clinical information

Did you have any difficulty using the LaserImplant system, including fitting the device? (If yes, please describe how)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Have any complications occurred as a result of using the LaserImplant system? (If yes, please describe how)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Did you experience any other issue relating to the LaserImplant product which you would like to comment on? (If yes, please describe)	No <input type="checkbox"/> Yes <input type="checkbox"/>

Technical information

Did you modify the LaserImplant device you received? (If yes, please describe how)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Do you have any comments regarding the technical information provided with the LaserImplant device? (If yes, please describe)	No <input type="checkbox"/> Yes <input type="checkbox"/>
Was a cleaning procedure completed at the hospital? (If yes, please describe the procedure)	No <input type="checkbox"/> Yes <input type="checkbox"/>
What sterilisation technique was used? (If yes, please describe)	No <input type="checkbox"/> Yes <input type="checkbox"/>
General comments/ideas/customer requests	

Form completed by		Signature		Date	
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