# CUSTOM IMPLANT ORDER

Physician Name: _____ Phone: _____

Physician Address: _____

_____

_____

Patient Name: _____ Surgery Date: _____

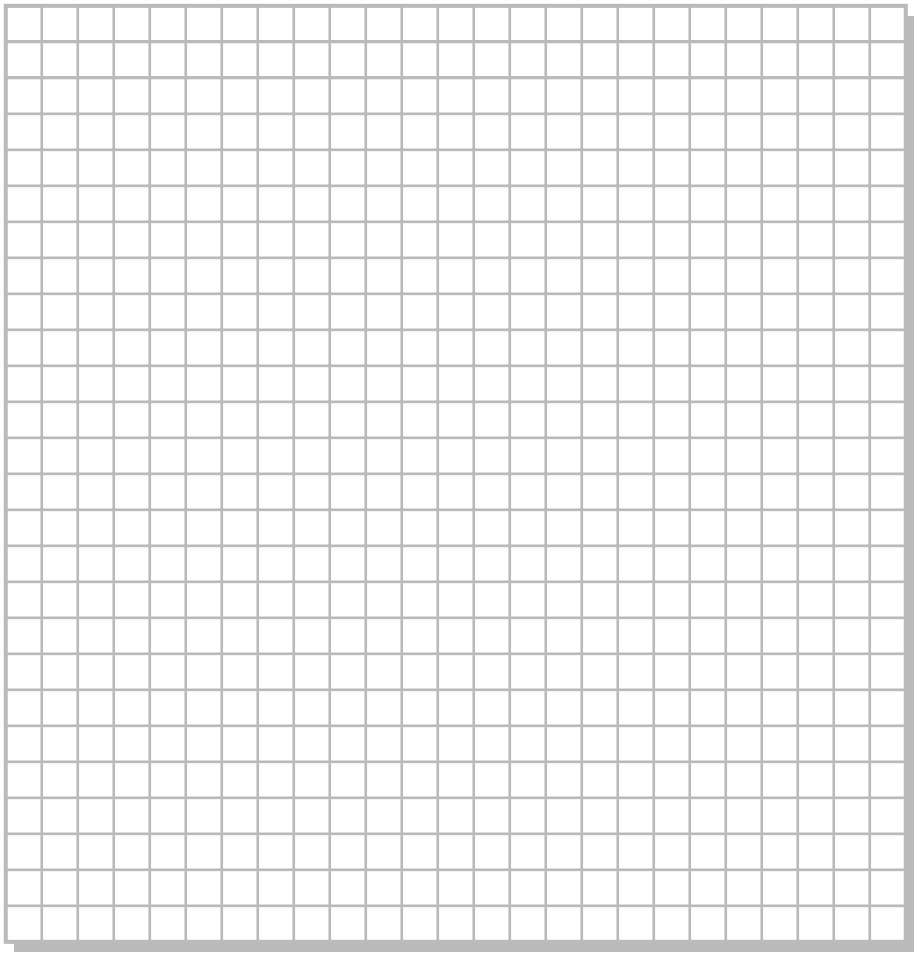
**All Custom Implant Orders must be pre-paid. Please allow at least four weeks for fabrication.**

**Surgeon's Certification and Signature**
I am relying on my own medical judgment as to the indications, contra-indications, safety and efficacy of the custom device and certify that it will be used under my personal supervision and is intended to meet my special needs in the course of my professional practice.

Surgeon's Signature: _____ Date: _____

**PLEASE PHOTOCOPY THIS FORM TO PLACE YOUR ORDER**

Sculpting clay moulage kits available; call (800) 367-0445



**Durometer**

❑ Firm
❑ Medium
❑ Soft
❑ Extra Soft

If your implant requires suture tabs, please indicate size and location.

Please sketch front, top and side views. Indicate dimensions:

1 block = _____ centimeter (s).

Notes:

Caution: United States Federal Law restricts this device to sale by or on the order of a licensed physician

Silmax® implants 800·367·0445 · Fax: 619·758·1431