

Clinician Name:
Hospital:
Delivery/Contact Address:

Telephone:
Email:
Lombard Medical/Distributor Representative:

Patient ID:
Date Of Birth: M/F:
Procedure Date:
CT Scan Date:

NOTES

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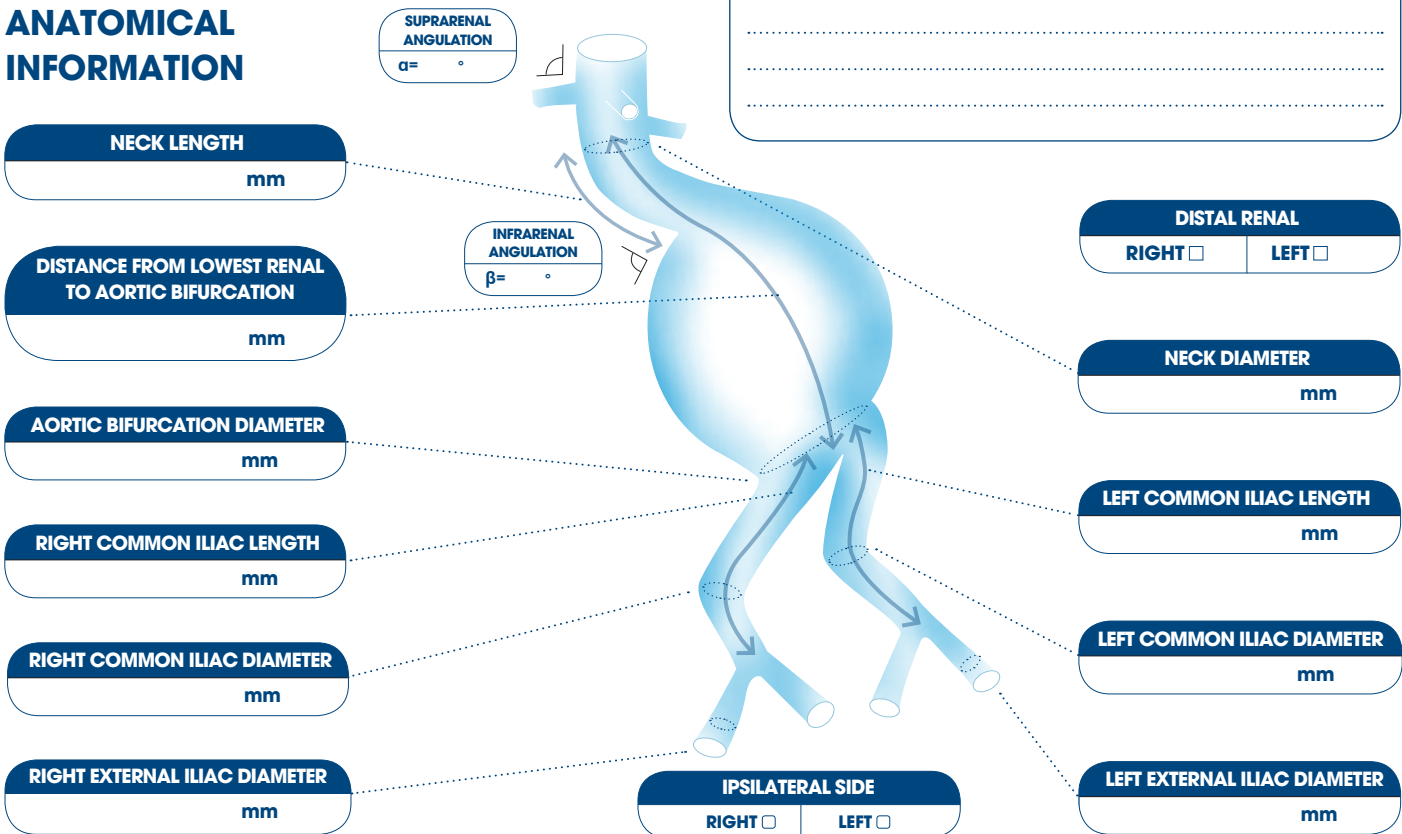
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ANATOMICAL INFORMATION



IMPLANT SIZES (please tick required graft size as appropriate)

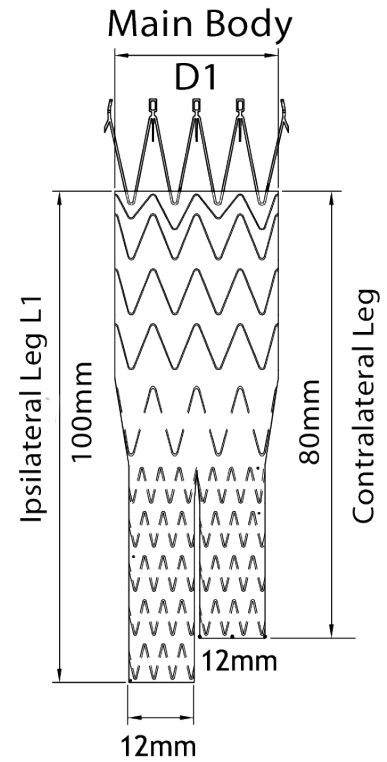
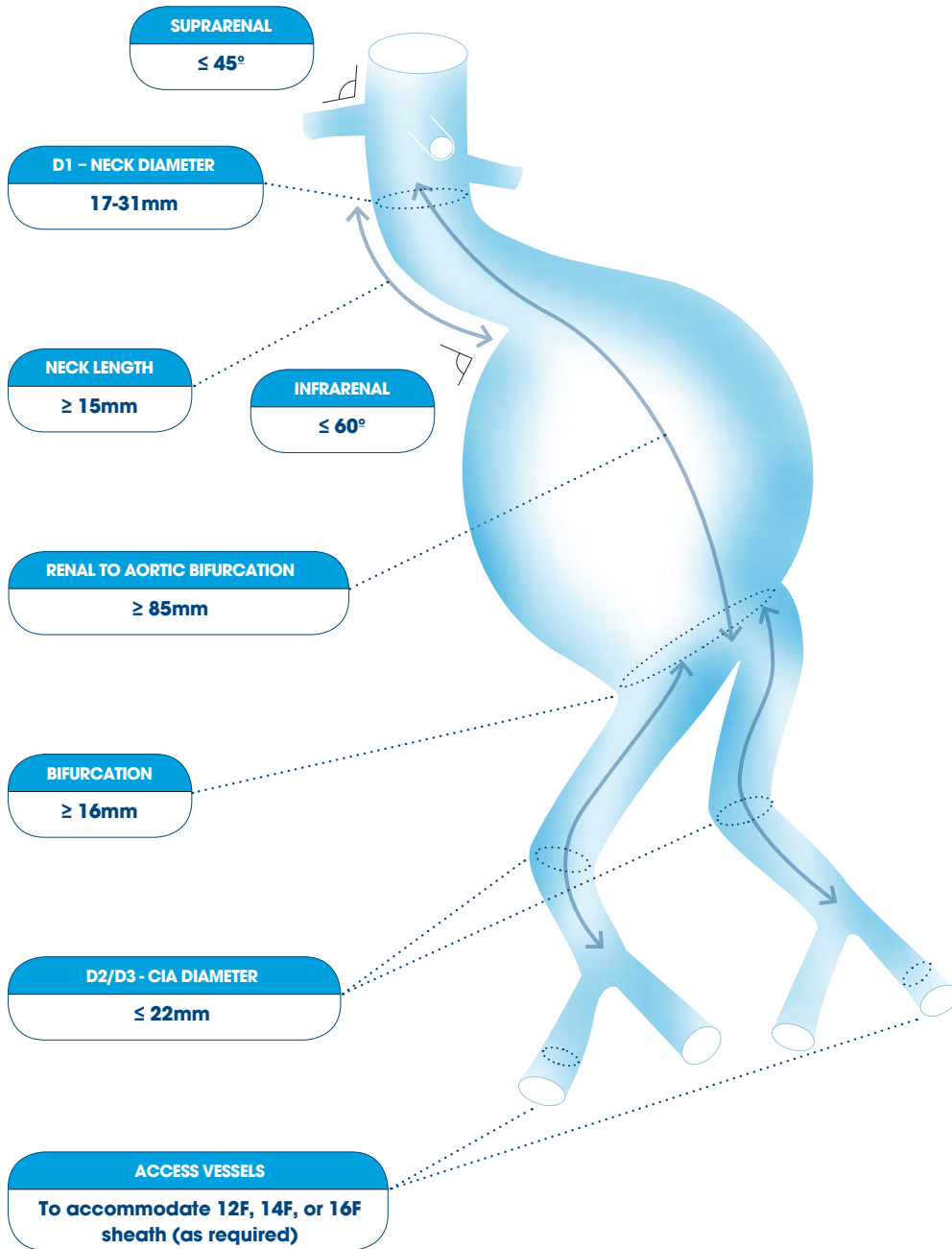
MAIN BODY		LIMB SIZES	
PROXIMAL DIAMETER (mm)	D1	IPSILATERAL LEG LENGTH (mm)	L2
	22 <input type="checkbox"/> 24 <input type="checkbox"/> 26 <input type="checkbox"/> 28 <input type="checkbox"/> 30 <input type="checkbox"/> 32 <input type="checkbox"/> 34 <input type="checkbox"/>		80 <input type="checkbox"/> 100 <input type="checkbox"/> 120 <input type="checkbox"/> 140 <input type="checkbox"/>
GRAFT BODY LENGTH (mm)	L1	DISTAL IPSILATERAL LEG DIAMETER (mm)	D2
	100 <input type="checkbox"/>		10 <input type="checkbox"/> 13 <input type="checkbox"/> 16 <input type="checkbox"/> 18 <input type="checkbox"/> 20 <input type="checkbox"/> 24 <input type="checkbox"/>
		CONTRALATERAL LEG LENGTH (mm)	L3
			80 <input type="checkbox"/> 100 <input type="checkbox"/> 120 <input type="checkbox"/> 140 <input type="checkbox"/>
		DISTAL CONTRALATERAL LEG DIAMETER (mm)	D3
			10 <input type="checkbox"/> 13 <input type="checkbox"/> 16 <input type="checkbox"/> 18 <input type="checkbox"/> 20 <input type="checkbox"/> 24 <input type="checkbox"/>

BODY AND LEG PRODUCT CODES FOR ORDERING

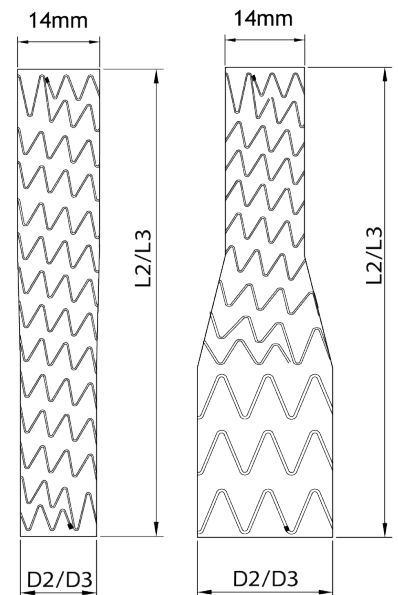
MAIN BODY	D1	L1	IPSILATERAL LEG	L2	D2	CONTRALATERAL LEG	L3	D3
		100						

If it is the responsibility of the clinician who completes this form to assess the suitability of this device for the intended patient. If this product is used outside of the indications for use, this is regarded as off label use and Lombard Medical cannot be held accountable for a decision to use it under these circumstances.

ANATOMICAL MEASUREMENTS



Iliac Leg



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