

Clinical 3D Modeling, Visualization & 3D Printing Request Form

Please email form to **apil@uhn.ca** or **Fax 416-340-3698 (c/o Sarah Russell)**

Contact Information

Request Date (dd/mm/yyyy)	
Service Required by Date (dd/mm/yyyy)	
Requester Name	
Requester Email Address* (UHN or other PHIPA Compliant)	
MRP Name (if different)	
MRP Email Address*	
Department/Division	
Contact Phone Number	

Service Requested (Check all that apply)

✓	Service Requested	Comments
	3D Digital Modeling from Medical Image Data	
	3D Printing	
	Screen-based Interactive 3D Rendering	
	Virtual or Augmented Reality Display	
	3D Scanning	
	3D CAD Design	

Please complete second page!

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Source Data (For Medical Image Based Requests)

✓	Source Type	Study Date (dd/mm/yyyy)	Accession #
	MRI		
	CT		
	3D Echo		
	3D Digital Model	<i>Submit model files to apil@uhn.ca. Include patient MRN in the subject line</i>	
	Purpose of model (e.g. pre-op planning, intra-operative use, shaping prosthesis, jig, sterility requirements)		
	Proposed Procedure or Intervention		
	Planned Procedure Date (dd/mm/yyyy)		
	Planned Procedure Site	<input type="checkbox"/> PMH <input type="checkbox"/> TGH <input type="checkbox"/> TWH <input type="checkbox"/> WCH <input type="checkbox"/> Other (Specify):	
	Other Data or Additional Comments. <i>If known, please indicate the DICOM seq # that best displays the key features of interest for image-based requests.</i>		

Payment Information

✓	Payment Method		
	FCC #		FCC signing Authority
	Invoice	<i>Payable by cheque, FCC transfer or Credit Card</i>	
	Other (specify)		