

Virtual Implant Positioning™

Place Patient Label Here:	Place Surgeon Practice Info Here:
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Scan this QR Code for CT Upload Instructions

For general questions, please contact your local Arthrex Representative

P A T I E N T	Date:	Patient Name:	SSN:
	Date of Birth:	Phone Number:	Work Phone Number:
	Insurance Provider:	Insurance Phone:	ID Number:
	Workers' Comp Adjuster Name:	Phone Number:	Claim Number:

Patient Consent for MyVIP™ Automated Texting Experience

CT shoulder without contrast. Please transfer DICOM to CD or upload directly to the facility's admin account.

IMPORTANT: The VIP™ system enables surgeons to preoperatively plan and select specific implants for their patients. Please follow the scan parameters below carefully.

Required VIP Scan Parameters

- VIP system uses only the thin axial images
- Reformatted images will not be accepted
- Start the CT scan several slices above the AC joint and include the entire scapula and proximal third of the humerus as small as possible
- The medial and inferior borders of the scapula must be included in the scan
- If the patient has any metal implants on the contralateral side, position the arm above the patient's arm above their head to minimize metal artifacts in the CT scan
- If the patient has metal implants on the affected side, use the appropriate metal artifact reduction algorithm per the manufacturer

Modality	CT
Recon Filter/Algorithm	Standard or Soft Tissue (not smooth, sharp, bone, nor detail); No contrast (NO arthrograms); Raw DICOM (grayscale only)
Scan Strength (kVp)	140 kVp (if available) or 120 kVp
Image Thickness	Max 1 mm (or less); minimum 0.2 mm; preferable 0.6 mm
Span Spacing	Contiguous slices
Pitch	< 1
Gantry	0° (no tilt)
Dose Modulation (mA)	300 mA with dose modulation; if modulation is not available, then 200 mA or higher depending on patient size

S U R G E O N	Diagnosis:	Laterality <input type="checkbox"/> Left <input type="checkbox"/> Right	Planned Procedure <input type="checkbox"/> TSA <input type="checkbox"/> RTSA <input type="checkbox"/> Both
	Referring Physician Signature: X	Referring Physician Name Print:	
	Phone Number:	Fax Number:	
	Street Address:	City, State:	ZIP:

